Department of Health Care Policy and Financing

Introduction

The Department of Health Care Policy and Financing (HCPF) is the state agency responsible for developing plans for financing publicly funded health care programs. The principal programs administered by HCPF include the Medicaid program, which provides health services to eligible needy persons, and the Children's Basic Health Plan (CBHP), which furnishes subsidized health insurance for children 18 years or younger in low-income families not eligible for Medicaid. The Medicaid grant is the largest federal program administered by the State and is funded approximately equally by federal funds and state general funds. CBHP was implemented in Fiscal Year 1998, and it serves as the State's version of the federal Children's Health Insurance Program. CBHP is financed by approximately two-thirds federal funds and one-third state funds. CBHP is marketed as Child Health Plan Plus, or CHP+. During Fiscal Year 2002 the Department expended in total about $2.5 billion and had 181 full-time equivalent (FTE) staff. In Fiscal Year 2001, HCPF expended $2.3 billion and had 172 FTE.

The public accounting firm of BKD, LLP, performed the audit work at HCPF as of and for the fiscal year ending June 30, 2002. During its audit, BKD, LLP, reviewed and tested HCPF's internal controls over financial reporting and federal programs. Also included was testing of HCPF's compliance with certain state and federal laws and regulations as required by generally accepted auditing standards, *Governmental Auditing Standards*, and U.S. Office of Management and Budget (OMB) *Circular A-133*.

Allowable Costs

Under the federal Medicaid program, certain expenditures are considered allowable costs and thereby qualify for reimbursement by the federal government. Total Medicaid program expenditures, excluding administrative costs, were over $2.3 billion for Fiscal Year 2002, which represents a federal share of just over $1.2 billion. The audit tested a stratified sample of 100 program expenditures and credits with a net value of $19,258,531 (federal share $9,629,266) for allowability under Medicaid regulations.

The types of errors identified in the sample continue to be similar to those found during the previous three fiscal years' audits. Overall, evaluation of the sample identified three program expenditures that did not comply with one or more of the allowable cost criteria for the Medicaid program. These three items had a value of $2,476 (federal share $1,238). The errors were as follows:

- **Prescription Credits.** Regulations allow the costs for prescriptions to be billed only if the recipient obtains the prescription within 14 days and the receipt is documented by the recipient's signature. Should a recipient not pick up a prescription within that time frame, the pharmacy is required to credit the original cost back to the Medicaid program. During our testing in Fiscal Year 2002, it was noted that in 1 of 10 pharmacy claims tested, the pharmacy provider was unable to furnish documentation indicating the recipient received the prescription within the 14 days.

In response to prior years' findings, during the third quarter of Fiscal Year 2002, the Department implemented procedures to monitor and periodically test the pharmacy signature logs to ensure the Medicaid program receives credit for prescriptions not claimed within 14 days. The pharmacy claim tested during the audit was from the period prior to the Department's implementation of these new procedures. The Department plans to continue its monitoring and testing procedures and review and reassess these as necessary.

- **Private Duty Nursing.** The one home health claim reviewed in the sample was for services that require prior authorization. No prior authorization was in the paper file, and the claim was processed through the Medicaid Management Information System (MMIS) and paid without MMIS's checking for a prior authorization. System edits within MMIS should be programmed to require that a prior authorization be entered for all such claims before the claim is approved for payment.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Allowable Costs.)

Recommendation No. 24:

The Department of Health Care Policy and Financing should ensure payments are made only for allowable costs under the Medicaid program by:

a. Continuing to monitor and document the results of the newly established procedures to randomly test pharmaceutical providers' compliance with

requirements for maintaining chronological logs of the Medicaid recipient signatures.

b. Performing periodic reviews of services that require prior authorization and ensuring that MMIS system edits are properly identifying and denying services lacking the required authorization.

Department of Health Care Policy and Financing Response:

a. Agree. A Medicaid bulletin was released to all pharmacies, physicians, and osteopaths in September of 2001 informing them of revised regulation 8.870.06 concerning obtaining signatures and return to stock/crediting provisions in cases where prescriptions are not picked up within 14 days.

Program Integrity implemented a process beginning the first quarter of calendar year 2002 whereby three pharmaceutical providers are randomly selected per quarter for review of claims submitted for a one-month period. Documentation is requested that supports obtaining the client's or their representative's signature at the time of picking up prescriptions, and the return to stock with credits for prescriptions not picked up within 14 days.

To date, nine pharmacies have been reviewed. Six cases have been closed without a recovery recommendation. Of these six, either there was 100 percent compliance to the regulation for the claims reviewed or the amount owed was below the $200 minimum recovery amount pursued by Program Integrity. The remaining three cases were closed with recommendations to recover. Program Integrity plans to continue random review of pharmacies on a quarterly basis.

b. Agree. The Department continues to work with the fiscal agent to ensure that the Medicaid Management Information System has edits designed to prevent payment for unauthorized services. The Department will review these edits to ensure they are being set properly. Further, the Department will review the services codes that are to be prior authorized to ensure that the authorization indicators are set correctly. Completion scheduled for this year's review is the end of March 2003.

Eligibility Databases Oversight

The audit reviewed the Department's procedures for complying with federal requirements for determining the eligibility of the individuals who receive benefits and the providers who receive reimbursements under the Medicaid program. HCPF has established an agreement with the Department of Human Services (DHS) to oversee the determination of an individual's eligibility for Medicaid through county departments of social services. These departments are under the oversight of DHS. County departments are responsible for inputting information related to an individual's eligibility into the Client-Oriented Information Network (COIN) system or the Trails information system, which track and monitor beneficiary eligibility. The information in COIN and Trails is used by MMIS in determining whether or not a claim should be paid on the basis of the individual's eligibility.

Individual Eligibility

The audit tested individual eligibility for 100 expenditures by reviewing paper files from the county departments of social services and comparing information from those files with the data maintained within the COIN and Trails systems. Though beneficiaries were eligible to receive the services provided for the sample claims selected, we identified numerous inconsistencies between information in the files and the data in COIN. These inconsistencies diminish the integrity of the data in the COIN system. Therefore, although the claims tested during our audit were appropriate for payment, there is a risk that other claims were, or could be, inappropriately paid or denied on the basis of erroneous information in COIN.

- In reviewing the eligibility for two beneficiaries, we found that although the claims in our sample were appropriately paid under Medicaid, documentation in the file indicated that the beneficiaries had died subsequent to the date of this claim. We noted that the Department made additional monthly capitation payments totaling $61 for services after the date of death for these two beneficiaries. There was no evidence that the Department had attempted to recover these payments made after the date of death for the beneficiaries tested by the auditors.

- In three instances, incorrect income amounts were reported in COIN, and in three other instances, incorrect disability codes were reported in COIN. As explained above, although the claims tested in our sample were appropriate for payment, incorrect information in COIN creates a risk that other claims may not be handled properly.

In our Fiscal Year 2001 audit, we recommended that the Department include in its eligibility testing an element of random sampling across all program areas. In its response, the Department reported that it does not perform random testing across all program areas and, instead, through a federally approved pilot project, targets eligibility testing toward areas considered to be of high risk. The Department indicated that it would develop a sampling methodology for use in the Colorado Benefits Management System (CBMS) that would allow it to sample all eligibility categories, and it anticipated that this methodology would be in place by August 2002.

As of the end of our Fiscal Year 2002 audit, the Department had not developed this methodology. It is important that HCPF develop a random sampling methodology in order to ensure that all areas are periodically tested for eligibility determination accuracy. In addition, periodic random testing would enable the Department to reevaluate its risk assessment. According to federal regulations, individuals must be eligible for the Medicaid program in order to receive benefits (42 CFR Part 435, Subparts G and H). By not ensuring that client eligibility is accurately determined and ensuring that eligibility information in COIN is accurate, HCPF risks that benefits may be paid on behalf of ineligible individuals. If erroneous payments are made, HCPF would have to repay to the federal government any Medicaid monies previously reimbursed to the State for these individuals.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Eligibility, Client Eligibility.)

Recommendation No. 25:

The Department of Health Care Policy and Financing should strengthen controls over the data in systems used as the basis for determining beneficiaries eligibility to receive Medicaid services by:

a. Performing random testing of eligibility information in the COIN and Trails systems and making corrections as appropriate.

b. Establishing procedures to ensure that COIN is updated accurately to reflect the date of death for all beneficiaries and that payments made after the beneficiary's death are recovered from providers.

Department of Health Care Policy and Financing Response:

a. Agree. Statewide random sampling will be possible with the implementation of the Colorado Benefits Management System (CBMS). Current implementation date is January 2004.

b. Agree. The Department agrees that data used as the basis for determining eligibility should be accurate. Currently the Department must rely on clients' families to report deaths and county departments of social/human services to record date-of-death information in COIN. To improve the accuracy of the data, the Colorado Benefits Management System (CBMS) will have an automatic interface with Department of Public Health and Environment's Vital Statistics data, ensuring far greater accuracy of the data on deaths in the State and preventing inappropriate payments for services. CBMS is scheduled to be implemented in January of 2004.

Provider Eligibility

The Department has contracted with its fiscal agent for the Medicaid program, Affiliated Computer Systems (ACS), to determine the eligibility of providers to receive reimbursement for services provided under the Medicaid program. As part of this contract, the fiscal agent is required to maintain documentation to support that the medical providers are licensed in accordance with federal, state, and local laws and regulations (42 CFR sections 431.107 and 447.10; Section 1902(a)(9) of the Social Security Act). Nonetheless, under federal regulations the Department of Health Care Policy and Financing remains ultimately responsible for the Medicaid program. This means that HCPF must have controls in place to ensure compliance with state and federal regulations for all aspects of the Medicaid program, whether performed directly by the Department or by another entity through contractual or other formal agreements.

During the Fiscal Year 2002 audit, a sample of 30 provider files was tested. Of these, only 6 files had documentation supporting licensure in the State to provide services, Electronic Data Interchange agreements, and provider agreements. The Department was able to request and resolve provider eligibility issues for sampled items. However, HCPF recognizes that documentation should be improved so that all required information is obtained and retained on a prospective rather than on a retrospective basis. The Department is currently in the third year of a five-year re-enrollment plan to update

provider files and address problems with maintaining current documentation of provider eligibility and required agreements.

During Fiscal Year 2002 the Department's provider enrollment committee continued working on provider reenrollment, as outlined in its strategic plan for addressing provider eligibility issues. The Department continued to terminate providers with unknown addresses, providers with only post office box addresses, and providers with no claim activity for the past three years. The Department is also continuing a reenrollment process for all the Primary Care Physicians (PCPs). This process requires PCPs to furnish updated provider agreements and proof of licensure.

Additionally, the Department is reviewing requirements under the federal Health Insurance Portability and Accountability Act and the potential for sharing electronic data on licensing information with other state and federal agencies. Currently the Department conducts a manual review of licensing information from the Department of Regulatory Agencies. If HCPF identifies Medicaid providers whose licenses are expired, revoked, or inactive, the providers are terminated in MMIS.

Controls over provider eligibility are important because if payments are made to ineligible providers, the Department must refund monies previously reimbursed to the State by the federal government. Therefore, the Department should continue its activities under its strategic plan for addressing provider eligibility, including efforts to ensure that the fiscal agent meets requirements related to provider documentation.
(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Provider Eligibility, Special Tests and Provisions.)

Recommendation No. 26:

The Department of Health Care Policy and Financing should continue to improve controls over provider eligibility by:

a. Requiring the fiscal agent to review all provider files to ensure each file includes a current provider agreement and documentation of applicable provider licenses and registrations.

b. Revising control procedures to ensure expenditures are made only to eligible providers.

c. Developing procedures to update provider licensing information on an annual basis to ensure its accuracy for changes that occur throughout a given year.

Department of Health Care Policy and Financing Response:

a. Agree. The fiscal agent will review files from December 1998 forward to make sure each file contains the provider agreement. Provider licenses are recorded in the Medicaid Information Management System and not the provider files. The Department continues to manually update provider licenses into the Medicaid Management Information System. This will be completed by November 1, 2003.

b. Agree. The Department continues to implement procedures to ensure that only eligible providers receive reimbursement. The Department continues to manually terminate providers who are found to be ineligible. This finding remains part of the Department's provider enrollment plan schedule for completion 2005.

c. Agree. Currently, there are no unique identifiers for medical professionals that would allow the Department to conduct data matches between Medicaid Management Information System and the databases maintained by the Department of Regulatory Agencies. Once the Health Insurance Portability and Accountability Act (HIPAA) is implemented, the Department will be able to use the National Provider Identification to update information systematically. The HIPAA provider identification number federal rule is estimated to be completed in early 2003. The Department will have two years from the time the rule is adopted to be in compliance. Until then, the Department continues to update the database manually.

Long-Term Care Documentation

The Department is responsible for ensuring long-term care facilities are receiving updated payment rates in a timely manner. During testing, it was noted that because of staff turnover, the Department experienced a lapse in date stamping rate revisions and reviews when the reviews were received from its contract auditor for long-term care facilities, as well as when the rate notifications were sent to the provider facilities. Because these documents were not date stamped, the Department was unable to demonstrate that providers were furnished with rate notifications and revisions within the 10 days required under state regulations (Staff Manual Vol. 8441.2-G). Further, the Department is required to issue quarterly summaries of each provider's Resource Utilization Groups (RUGs); these summaries identify a snapshot of patients' acuity levels in a given long-term care facility at

a point in time. The Department must submit these summaries to facilities for their review and correction because HCPF uses patient acuity levels in assessing revisions to facilities' rates. The Department did not date stamp the issuance and receipt of the RUGs quarterly summaries, and therefore, HCPF cannot demonstrate that it conducted this process in accordance with required timelines.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Special Tests and Provisions.)

Recommendation No. 27:

The Department of Health Care Policy and Financing should date stamp all rate revisions and reviews when received and all rate information sent to provider facilities.

Department of Health Care Policy and Financing Response:

Agree. Effective November 1, 2002, the Department implemented date stamping procedures—for both rate calculation receipt and issuance to providers—to demonstrate compliance. Additionally, date stamping procedures have been implemented for the quarterly case mix validation summaries. The Program Operations Manager position is now responsible for maintaining these procedures and for monitoring staff compliance on an ongoing basis.

Outpatient Hospital Settlements

In Fiscal Year 2002, HCPF reimbursed hospitals $52.8 million for outpatient services. Certain outpatient hospital services are reimbursed on the basis of a hospital's actual cost, less a Medicaid outpatient cost reduction of 28 percent. The Department pays claims for outpatient services to participating hospitals by using payment rates based on estimated costs. Federal regulations require that the Department perform an annual retroactive cost settlement for each facility and make appropriate adjustments to ensure the facility is reimbursed on the basis of the hospital's actual costs. The Department uses an independent contractor to complete the cost settlement process. Since Affiliated Computer Systems (ACS) became the State's Medicaid fiscal agent in December 1998, the contractor has been unable to calculate these cost settlements with providers because ACS has not produced reports required for the settlement process. As a result, HCPF has not issued any rate settlements for outpatient hospital services to providers since 1997.

Two essential components utilized in settling these service rates are (1) the provider's Medicare cost-to-charge ratios, which are calculated in the provider's Medicare cost report, and (2) a summary of the provider's paid Medicaid outpatient claims, which should be furnished by the Medicaid fiscal agent. The fiscal agent is responsible for processing all Medicaid claims through MMIS. Providers were required to file their Medicare cost reports for 1998 with the Medicare fiscal intermediary approximately five months after their facility's cost reporting year-end. In many instances, these cost reports have already been finalized for Medicare purposes. The cost reports have not been completed for Medicaid purposes because the Medicaid fiscal agent has not been able to produce accurate summary claim reports on outpatient services. Therefore, the Department does not know whether a facility has been underpaid or overpaid for these services after 1997, or by how much. Upon completion of these cost settlements, there is the potential that the Department will be required to make significant adjustments related to these cost settlements, although the overall impact of these adjustments is not known.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Special Tests.)

Recommendation No. 28:

The Department of Health Care Policy and Financing should require that the fiscal agent generate accurate claims summary reports for settling all hospital outpatient service claims payments within a specified time frame. If reports meeting the Department's requirements are not produced within the time frame, the Department should assess liquid damages against the fiscal agent.

Department of Health Care Policy and Financing Response:

Agree. Cost settlement reports run 10 months after the provider's fiscal year ends. Cost settlement reporting is now in production. The Department needed to retroactively run 1998 and 1999 cost settlements. The reports for 1998 will be completed by December 31, 2002, and the reports for 1999 will be completed by January 31, 2003. The fiscal intermediary is now in compliance with the ongoing production of the cost settlement reporting requirements.

Residential Treatment Centers Overview

Residential treatment centers (RTCs) offer 24-hour care and mental health services to youth up to age 21 who are determined to be mentally ill. Youth may be placed in an RTC either by the Division of Youth Corrections (DYC) or county departments of social services. During the first six months of Fiscal Year 2001, counties had about 1,340 youth in RTCs each month while DYC had about 251 youth. For youth discharged from DYC during Fiscal Year 2001, the average length of stay in an RTC was about seven months. Similar data are not available regarding youth placed by counties due to problems with the Colorado Trails system. RTCs represent the most expensive out-of-home placement option, costing an average of about $53,000 per youth per year for room and board and mental health treatment services. This increases to an average of about $67,000 per youth per year for those RTCs that also have an approved on-grounds school.

Funding for the RTCs comes from a combination of state funds, county funds, and federal funds. The rate paid to RTC providers comprises three components. Mental health treatment services represent the largest component of the rate. Mental health services are funded through Medicaid. RTCs receive a flat daily rate based on the youth's Level of Care (A, B, or C). Most youth are assigned to Level B. In Fiscal Year 2001, Level B treatment rates, the standard for RTCs, varied from $33,310 per year to $47,684 per year depending on the facility. The second component of the rate covers room and board expenses. Room and board rates are set through competitive bidding by DYC and negotiation by counties. Room and board expenses are paid using state and county funds and range from $6,672 per year to $22,287 per year depending on the facility, the youth, and whether DYC or a county places the youth. The third component of the rate is paid to approximately 38 RTCs that have approved on-grounds schools enabling them to receive reimbursement from the Colorado Department of Education and local school districts. In Fiscal Year 2001, per pupil operating revenue (PPOR) and excess cost payments varied from $6,329 to $18,199 on an annual basis.

During Fiscal Year 2002 the Office of the State Auditor conducted a performance audit of the Residential Treatment Center Rate Setting and Monitoring process. The audit comments below were contained in the *Residential Treatment Center Rate Setting and Monitoring Performance Audit,* Report No. 1406, dated January 2002.

Controls Over Claim Payments

In Fiscal Year 2001 the State paid residential treatment centers approximately $69.2 million for mental health services. Medicaid claims are paid through the State's Medicaid

Management Information System (MMIS). The Department of Health Care Policy and Financing (HCPF), the Department of Human Services (DHS), and the State's fiscal agent, Affiliated Computer Systems, Inc. (ACS), formerly known as Consultec, share the responsibility for ensuring that only accurate and allowable claims are paid.

During our audit we reviewed the claims submitted by RTC providers for treatment services provided to county-placed youth. As noted earlier, mental health treatment services are reimbursed on a flat daily rate depending on the level of care. Due to the fact that Colorado Trails contains incomplete data, we had to use room and board payment data from the system that was in existence prior to Trails (the CWEST system). We compared the billing and payment information in MMIS with room and board records in CWEST to try to match room and board claims to mental health treatment claims for all youth receiving services in August 2000. Our review of 1,497 Medicaid claims indicated inadequate controls over the payment of these claims.

Errors in Medicaid Payments for RTC Claims

Our audit focused on whether RTC providers accurately submitted Medicaid claims for allowable costs. Of the 1,497 claims reviewed, we found at least one error in 455 (30 percent) of them, totaling over $98,000 in erroneous payments for August 2000. Annualized, this could amount to over a million dollars in inaccurate payments.

We identified 147 claims for amounts that did not correspond to any of the established Level of Care rates for a particular provider. For example, one provider appears to consistently be charging about $6.00 more per day than the Level of Care B rate for 14 of the 17 youth it served in August 2000. For the days the 14 youth were served, we estimate the provider received about an extra $2,000. Dates of services for treatment claims did not match room and board dates in 211 claims. Thirty-four percent of those with dates of service that did not match resulted in apparent overbilling. Providers appeared to bill for treatment services for youth who, according to corresponding room and board payments, had not yet entered the RTC or had already left. We also found 108 claims submitted by providers that appear to be bills for the last day of service, which is specifically prohibited by Department of Human Services rules. Finally, we found numerous inconsistencies with the information internal to the youths' MMIS payment record. These included submitting two separate and different calculations of dates of service and improper account codes.

Inadequate controls over RTC Medicaid claim payments include the following:

a. **Basic System Edits.** We found that basic edit checks are needed. For example, although RTCs are supposed to submit claims based on three Levels of Care, the MMIS system only contains the rate matching the highest and most expensive level—Level C. In other words, MMIS contains an upper payment limit but lacks controls over specific payment levels. As noted in our 2001 Medicaid Management Information System report, ACS, the State's fiscal agent, has had difficulty keeping up with edit change requests. We found that, over two years ago, HCPF submitted a Change Request Letter to ACS to input all three Level of Care rates. To date this has not been done.

   Second, although Division of Child Welfare representatives informed us that they believe MMIS should contain edits to ensure that dates of service are accurate, this is not the case. ACS representatives indicated that they check to ensure that the youth is Medicaid-eligible, but that the MMIS system does not cross match the days of service or whether the youth is actually at the RTC with the Department of Human Services systems (Colorado Trails or CWEST).

b. **Claims Review.** RTC claims are not routinely sampled to ensure accuracy. The Department of Health Care Policy and Financing (HCPF) has general procedures in place to review all Medicaid claims. Claims audits are conducted by Information Section and Program Integrity Unit staff. The Information Section staff conducts a quarterly audit of a sample of claims from all 13 Medicaid categories to ensure the accuracy of the system's payment process. RTCs are included in the criteria for the sample, but there is no guarantee that an RTC claim will actually be selected. In addition, the Information Section audit focuses on whether payments are made in accordance with the edits in the MMIS system. For RTCs, the check would be to ensure that the claim does not exceed the Level C rate, not whether the RTC provider submitted a claim for the proper rate. The Program Integrity Unit investigates allegations of improper billing but does very little related to RTC payments. Staff noted only one case in the last year involving an RTC and it was a placement rather than a billing issue.

   In addition to the oversight currently done by the Department of Health Care Policy and Financing, the Department of Human Services has access to the MMIS system and could check the accuracy of claims. However, the Division of Child Welfare staff noted that the one FTE designated for the RTC program is focused on other duties. The Division tracks the total Medicaid amount spent by each county for RTC placements. While these data can be used by counties to try to get a picture of their standing in terms of overall appropriated monies, they do not provide any information related to the accuracy of claims payments.

As already noted, we identified errors in 30 percent of the claims we reviewed. We believe that the Department of Health Care Policy and Financing and the Department of Human Services need to perform more program-specific sample claims audits. We note that the MMIS system has the ability to produce RTC claims reports to include both summarized information and individual claim data for such an analysis.

c. **Compliance With Approved Vendor List:** Finally, a good system of internal controls would include checks over vendors. Department of Human Services rules state that payments cannot be made to a provider unless that provider is listed on the Division of Child Welfare's approved vendor list. This is meant to ensure that only those providers who meet all state licensing requirements serve youth and receive the corresponding state payments. We found two providers are currently receiving placements from the counties and submitting claims for Medicaid reimbursement, even though they are not on the approved vendor list. We asked Division staff to determine if these vendors were approved. They informed us that in these two cases the providers met all requirements and their absence from the vendor list was a documentation error. To date, however, the Department has not corrected its vendor list. Maintaining an accurate list and checking it prior to payment is important in expediting claims and ensuring accuracy.

   We also spoke with the RTC Administrator about how the vendor list is amended and ACS notified of those providers who are no longer eligible for RTC placements. The Administrator stated that he verbally informed ACS about those providers that had closed but had not sent an official transmittal letter removing them from the MMIS system because those providers had outstanding Medicaid bills to be paid. The two departments need to develop payment cutoff points to ensure that these providers do not continue to bill ACS for mental health treatment services. The RTC Administrator also needs to ensure that the vendor list is updated to accurately reflect eligible providers and existing reimbursement rates.

In conclusion, our review indicates the possibility of over $98,000 in Medicaid overpayments during the month of August 2000 alone resulting from a lack of payment controls. The State has the responsibility for ensuring that only accurate and allowable Medicaid bills are paid. Although Medicaid-funded mental health treatment services are an entitlement, overpayments are inappropriate and impact county finances. Counties are responsible for using their own funds to pay the Medicaid match when the block funding has been exceeded. In addition, failing to audit the claims leaves open the potential for Medicaid fraud. The State, through the Department of Health Care Policy and Financing

and/or the Department of Human Services, needs to conduct periodic audits of the MMIS billing and payment information related to RTC providers to ensure accurate payments. In addition, the Department of Health Care Policy and Financing should work with ACS to establish additional edits in the MMIS system that will help prevent inaccurate billings. In regard to the potential overpayments due to the lack of payment controls, HCPF needs to recover these overpayments.

The counties and DYC are in the best position to verify the accuracy of RTC provider billing and payment information. These entities authorized the placement of the youth and, therefore, know the authorized rate. They also have placed the youth and thus they know the providers and the true dates of service. In addition, DYC and the counties have both a financial and an operational need to verify RTC billing information. On the financial side, counties and DYC need to operate this program within authorized spending authority. From the operational perspective, the counties and DYC must ensure that RTC providers charge for the youth's approved Level of Care.

In addition, HCPF could require ACS to cross-check payment claims with the room and board information in the Colorado Trails system. Division of Child Welfare representatives informed us that the room and board information in the Colorado Trails system should accurately reflect the placement of the youth and the days of service. Such cross-checking would prevent the payment of claims for last day of service and billing for days in which the youth was not in the RTC. However, this would involve allowing ACS access to the Colorado Trails system and a willingness by ACS to perform these checks prior to payment. ACS representatives informed us that they could perform such cross-checking but that it could lead to additional costs under the contract.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Activities Allowed or Unallowed, Allowable Costs/ Cost Principles, Eligibility.)

Recommendation No. 29:

The Department of Human Services should implement procedures to ensure that it pays only allowable costs for RTC services. This could be accomplished by verifying the accuracy of RTC provider billing and payment information through periodic audits.

Department of Human Services Response:

Agree. Estimated Completion Date: No later than July 1, 2003. Since counties and DYC already verify room and board payments, the Department will require

providers to route treatment invoices through the placing county or DYC to similarly verify Medicaid treatment payments for ACS.

Recommendation No. 30:

The Department of Health Care Policy and Financing should implement procedures to ensure that it pays only allowable costs for RTC services by:

a. Verifying the accuracy of RTC provider billing and payment information through periodic audits.

b. Requiring Affiliated Computer Systems, Inc., the State's fiscal agent, to include additional payment edits within the Medicaid Management Information System to ensure that the system has adequate controls to prevent inaccurate billing.

c. Seeking to recover overpaid amounts for the prior periods.

Department of Health Care Policy and Financing Response:

a. Agree. The accuracy of payment will continue to be a part of the Claims Processing Assessment System (CPAS) reviews. However, as noted in the narrative, these reviews only assess whether the system paid the claim correctly according to the policy that is implemented within the system. It is the obligation of the provider to properly bill for the services rendered. The Program Integrity Unit within the Quality Assurance Section will conduct random sample monitoring to assess whether this is done correctly. This monitoring will commence in March 2002. Recommendations for a recovery plan will result from the sampling. The Department anticipates recovery on substantiated overpayments to begin August 2002, or within two months of being identified.

   Human Services staff continue to use the Executive Information System/Decision Support System to review claims for services. Through the use of this capability, staff would be able to compare claims data with the records at the RTC and the local agencies for appropriateness of billing, and compare their list of valid RTC providers with the definition used by the Medicaid Management Information System to ensure payments to only valid providers.

b. Agree. The Medicaid Management Information System change request to accommodate the three pricing levels was put in the queue in September 1999. There are policy decisions that need to be made about how to handle the problems identified in this audit. The design considerations include the use of prior authorizations, coding of services, and other possible solutions. Once the policy decisions are made, the systems changes to implement the policies can be made within six months. Health Care Policy and Financing commits to working with Human Services staff to resolve the policy issues. It is anticipated that the systems changes will be in place by the end of October 2002.

c. Agree. The Department will pursue recoveries through the work done by Program Integrity (described in item a). Once identified and substantiated, the recovery process can begin within two months, though it may take longer than that to receive all the identified money. As Department of Human Services identifies overpayments, financial transactions can be entered into the Medicaid Management Information System to make recoveries from providers from current payments. Other recovery methods will be explored with Human Services.

Colorado Indigent Care Program

The Colorado Indigent Care Program (CICP) promotes access to health care for low-income state residents who are uninsured or lack adequate insurance (e.g., their benefits are exhausted or limited) and are not eligible for Medicaid. The program is administered by the Department of Health Care Policy and Financing (HCPF).

CICP was not designed or intended to be an insurance plan and does not qualify as one under state law. Statutes describe the program as a "partial solution to the health care needs of Colorado's medically indigent citizens" (Sec. 26-15-102 (2), C.R.S.). In practice, CICP is a financing mechanism through which the State reimburses participating providers for a portion of the costs incurred in treating individuals that meet CICP eligibility requirements. In turn, participating providers must adhere to state-established limits for amounts charged to CICP-eligible individuals. Thus, CICP promotes access to health care services for low-income uninsured individuals by helping to defray providers' costs of furnishing care and by limiting the amount that individuals receiving the care must pay. CICP is funded through Medicaid funds made available to states under the Disproportionate Share Hospital program and the Major Teaching Hospital program.

During Fiscal Year 2002 the Office of the State Auditor conducted a performance audit of the Colorado Indigent Care Program. The audit comments below were contained in the *Colorado Indigent Care Program Performance Audit*, Report No. 1391, dated March 2002.

Overlap between Medicaid and the Colorado Indigent Care Program

The Colorado Indigent Care Program is one of several state programs that provide health care to indigent individuals. The Medicaid program also serves this population and is administered by the Department of Health Care Policy and Financing. Although both CICP and Medicaid target roughly the same population, there are important differences between the programs, ranging from how the programs are financed to beneficiary eligibility requirements. From a budgetary perspective, the most important distinction is that the Medicaid program is an entitlement under federal law. This means that the program must serve all individuals who meet the program's eligibility rules. CICP is not an entitlement program, and therefore the State can limit expenditures as necessary. Another important distinction is that, unlike the Medicaid program, CICP is not an insurance plan with established benefits and a roster of beneficiaries.

Because of the similarity in the target population for CICP and Medicaid, some individuals may be eligible for both programs. However, state law prohibits individuals eligible for Medicaid from being served by CICP. Some of the significant differences in the eligibility requirements for the two programs include that, as an individual's age increases, the maximum income allowable under the Medicaid program decreases. Young children are eligible for Medicaid if their family's income is less than 133 percent of the federal poverty level (FPL); however, when a child turns six, the family income cannot exceed 100 percent FPL. Further, with the exception of elderly persons and persons with disabilities, for an adult to qualify for Medicaid, he or she must be a parent or guardian of a Medicaid-eligible child. Individuals who are not eligible for Medicaid may be eligible for CICP. Thus, a high proportion of individuals served in CICP are low income, single adults less than 65 years of age.

In order to determine what types of overlap might exist between the Medicaid program and CICP, we examined a sample of CICP charges to determine if participating providers were submitting charges to CICP for individuals who were simultaneously enrolled in the Medicaid program. For our sample, we selected CICP charges for services rendered in April 2000. Using social security numbers, we compared the list of individuals receiving

these CICP services with Medicaid eligibility information for April 2000 maintained by HCPF.

We identified about 1,600 unique individuals who were enrolled in Medicaid on the same date they received services that were charged to CICP. The total amount of CICP charges for these individuals was about $2.3 million, and we estimate that providers would have been reimbursed about $554,800 on the basis of these charges. In almost half of these cases, the individual had been determined Medicaid-eligible at least three months prior to April 2000. In the remaining cases, Medicaid eligibility may have been pending in April 2000 and providers may have subsequently reversed the CICP charges. However, HCPF has no effective way to determine whether such adjustments were made.

The State is in the process of developing the Colorado Benefits Management System (CBMS), which is intended to be an eligibility system for the Medicaid program and CICP, as well as numerous public assistance programs such as Temporary Assistance for Needy Families, Food Stamps, and the Old Age Pension program. In the case of the two health care programs, CBMS will verify that an individual is not eligible for Medicaid prior to enrolling the person in CICP. This should help ensure that individuals are enrolled in the correct program. CBMS was scheduled to be operational by July 2003; however, the Department reports that recent discussions indicate implementation may be delayed.

Some of the problems identified during out audit would presumably be addressed by CBMS in the future. However, we also found problems with retroactive adjustments that CBMS is not likely to address.

Reasons for Overlaps Between CICP and Medicaid

Medicaid-eligibility screening. Because about half of the overlaps occurred in cases in which individuals had been eligible for Medicaid for a number of months, this indicates that the providers are not effectively screening individuals for Medicaid prior to designating them as eligible for CICP. This is concerning because providers receive better reimbursement under Medicaid and individuals receive better benefits and pay lower copayments. In addition, it is not in the State's best interest for Medicaid individuals to be served under CICP, because the federal funds that are used to finance CICP are limited. Further, the majority of Medicaid recipients are enrolled in some type of managed care program, which means that the State pays a monthly capitation payment for some or most of the services a Medicaid client receives. If the State is also paying for services for these individuals through CICP, the State is, in effect, paying for the same service twice.

To address eligibility determination problems, HCPF should work to improve Medicaid screening during the CICP eligibility determination process by emphasizing screening procedures during the eligibility training workshops for providers.

Retroactive adjustments. For the remaining cases in which Medicaid eligibility was determined three months prior to April 2000 or in April 2000, there are timing issues (e.g., 90-day retroactive Medicaid-eligibility for an individual) that could explain why a provider might submit CICP charges for a client who is listed as Medicaid-eligible for the same time period. Our analysis did not cover a sufficient period of time to determine how many of the seemingly erroneous charges to CICP might have been subsequently reversed by providers. However, we found that the Department lacks clear procedures and good information about whether or not providers are making retroactive adjustments when individuals initially classified as CICP-eligible are later determined to be Medicaid-eligible. Under state law, only county departments of social services can determine Medicaid eligibility. Therefore, providers can only screen for Medicaid and must refer patients to the counties for a formal determination of Medicaid eligibility.

Similarly, a person may have a Medicaid application pending with the county when he or she needs services. In these cases, the provider cannot classify the person as Medicaid-eligible, regardless of how likely it may appear. However, providers can determine CICP eligibility; and, therefore, if the person's Medicaid status is unclear and the individual meets CICP requirements, the provider will classify the charge under CICP. If a person is later determined by the county to be eligible for Medicaid, Medicaid will cover any services incurred up to 90 days prior to the date of eligibility determination. Therefore, the provider must then reclassify the CICP charge as a Medicaid charge.

The Department depends on providers to reclassify these CICP charges. As mentioned above, our analysis did not cover a sufficient period of time to allow us to assess whether or not these adjustments had taken place. However, we found that the CICP manual does not give providers clear instructions on how adjustments should be reported. These procedures are documented in the section with the provider audit guidelines and not in any section that outlines procedures for providers themselves. The Department reports that it receives some letters from providers regarding refunds to CICP based on later adjustments.

Without clear instructions to providers regarding how post-year-end adjustments should be tracked and reported, the Department lacks assurance that it receives all refunds due to CICP or that these adjustments are handled appropriately. For example, the Department reports that one provider deletes a sufficient number of CICP charges from the current fiscal year to offset the amount of retroactive Medicaid adjustments for prior

year CICP clients. This may result in charging the correct net amount to CICP. However, it means that utilization numbers for CICP services may not be accurate and that the Department lacks knowledge of whether any adjustments were made.

(CDFA Nos. 93.777, 93.778; Medicaid Cluster; Other.)

Recommendation No. 31:

The Department of Health Care Policy and Financing should follow up on the results of the data match performed by the Office of the State Auditor between the Colorado Indigent Care Program and the Medicaid program. HCPF should contact providers, as appropriate, that submitted CICP claims for individuals who are eligible for Medicaid and request that providers report on how adjustments to CICP charges have been made for these claims. It should seek reimbursement as appropriate.

Department of Health Care Policy and Financing Response:

Partially agree. The Department notes that there is not evidence that a duplicate claim was filed with both the Medicaid program and CICP. The Department does not plan to contact providers regarding the finding of the Office of the State Auditor, due to limitations of the sample size. However, the Department will work toward identifying the scope of the issue and will take steps to both clarify policy and, to the extent possible, eliminate or minimize the problem in the future. The Department will clarify language in the Fiscal Year 2002-2003 CICP Manual that outlines procedures and policy in an attempt to minimize this problem in the future by July 1, 2002.

Auditor's Addendum

Our audit identified instances of possible overpayments to CICP providers for individuals that were eligible for Medicaid at the time CICP services were rendered. The detailed results of our data match are being provided to HCPF. Addressing known problems is essential for program integrity, and in this case, can be accomplished by distributing information from the data match to the providers for their review and follow up.

Recommendation No. 32:

The Department of Health Care Policy and Financing should ensure that applicants for the Colorado Indigent Care Program are screened for Medicaid eligibility in all appropriate instances by training providers on Medicaid eligibility screening procedures outlined in the CICP manual.

Department of Health Care Policy and Financing Response:

Agree. The Department will strengthen the CICP eligibility training and include further training on the Medicaid eligibility screening procedures that are already outlined in the CICP manual. This material will be included in the CICP eligibility training by July 1, 2002.

Recommendation No. 33:

The Department of Health Care Policy and Financing should ensure post-year-end retroactive adjustments are made to charges for the Colorado Indigent Care Program by developing and implementing procedures for providers to report these adjustments and related information to the program.

Department of Health Care Policy and Financing Response:

Agree. The Department has already taken steps to clarify the guidelines outlined in the current CICP manual so all providers are aware of the procedures to report retroactive adjustments. These procedures will be included in the Fiscal Year 2002-2003 CICP Manual. The Department will implement the procedures for making adjustment by October 31, 2002, so the information will be included with the final Fiscal Year 2001-2002 cost data submitted by CICP providers.

Clarification of Policies on Charges to Be Submitted to CICP

In Fiscal Year 2001, the Colorado Indigent Care Program paid participating providers about $131.9 million as partial compensation for the cost of providing care to low-income individuals eligible for CICP. Under CICP, providers are placed into one of three categories (Component 1A, Outstate hospitals, and Outstate clinics), depending on the type of provider and the provider's Medicaid utilization rate. During the year there were 66 providers in the program, including 17 clinics in the Outstate clinic category, 40 hospitals in the Outstate hospital category, and 9 hospitals in the Component 1A category. In total, these providers submitted over $382 million in CICP charges. These charges are the primary basis upon which the Department determines payments to providers.

Our audit examined the Department's policies and procedures for making payments to CICP providers. Our objectives were to determine if the Department's payments were calculated accurately and on an equitable and appropriate basis for all providers within each category (Outstate clinics, Outstate hospitals, and Component 1A hospitals). As mentioned, payments to CICP providers are primarily made on the basis of CICP charges and estimated costs; in Fiscal Year 2001 about $89.3 million (68 percent) of the $131.9 million in payments to CICP providers were calculated on this basis. The remaining $42.6 million was composed of $21.2 million in additional payments under the Major Teaching Hospital program and $21.4 million in bad debt payments. Because the majority of payments are based on CICP costs derived from CICP charges, and because the calculations required for these payments are more complex, our audit focused on the payments the Department calculates using CICP charges.

In order to determine CICP *costs*, the Department must compile information on CICP *charges* and then, using a cost-to-charge ratio, calculate the estimated CICP costs of those charges. Charges are those amounts that providers bill for the services they render to CICP-eligible individuals. Because of the time it takes to compile CICP charges from all providers at the end of the fiscal year, the Department calculates the current year's reimbursements on the basis of actual CICP charges from two years prior. For example, the reimbursement payments for Fiscal Year 2002 are based on providers' CICP charges submitted for Fiscal Year 2000 and the related estimated costs of those charges.

To calculate each provider's payment, total CICP charges are first reduced by payments from third party payers (payments from other insurance plans, if the individual has other coverage) and the patient's liability (i.e., copayment) to arrive at write-off charges. Second, write-off charges are multiplied by a ratio based on total allowable Medicare

costs and charges (referred to as a provider's "cost-to-charge ratio") from the provider's most recent Medicare cost report; this calculation yields the provider's estimated cost of serving CICP clients. Third, write-off costs are inflated two years ahead to compensate for the two-year time lag between the base year (the year in which the charges occurred) and the year for which reimbursements are being calculated. Lastly, the inflated estimated costs are multiplied by the reimbursement rate for the provider's category to arrive at the provider's projected payments for the fiscal year. For example, for Fiscal Year 2002 these rates are 28.8 percent for Outstate clinics, 28.8 percent for Outstate hospitals, and 85.3 percent for Component 1A hospitals.

In order to determine the accuracy of the projected amounts for provider payments for Fiscal Year 2002, we reviewed the charges submitted to the Department for Fiscal Year 2000 because, as stated above, these were the charges upon which the Fiscal Year 2002 reimbursements are based. Our audit tested a sample of 25 charges each from University Hospital and Denver Health to determine if the charges were for CICP allowable services and provided to eligible individuals. In addition, we tested whether the information submitted to HCPF for the charges was consistent with the underlying data maintained by the provider. These two providers render the highest volume of services under CICP and receive the highest dollar amount of payments. For example, in Fiscal Year 2001payments to these two providers accounted for over 69 percent of all CICP payments in Fiscal Year 2001 that were made on the basis of CICP charges.

Out of the 25 Fiscal Year 2000 charges we examined for each of these providers, we found errors in 10 of the charges (40 percent) at Denver Health and 5 of the charges (20 percent) at University Hospital. Generally, the errors related to eligibility documentation and incorrect copayments. Since Fiscal Year 2000, Denver Health reports that it has improved its ability to locate eligibility documentation by implementing a new system that scans applications directly into the system. Additionally, Denver Health has instituted a quality review process to reduce errors related to copayments. The errors we identified at both providers were generally consistent with the results of the annual CICP provider audits and indicate the need for the Department to have an effective audit process for CICP.

Inconsistencies in Calculating Write-Off Charges

The issue identified that was of greatest concern, however, and which was not identified during the annual provider audits, was that the two providers included different amounts in third party payments. Due to their different interpretations of what was allowable under state and federal laws and regulations, the two providers calculated third party payments differently and reported this information, along with CICP charges, to the Department. This

caused a lack of consistency in how write-off charges were calculated for the providers, and, as a result, these providers' payments were calculated using inconsistent data.

The discrepancy stemmed from instances in which an individual was eligible for both Medicare and CICP. Of the 25 charges tested at University Hospital, we identified 3 charges (12 percent) for which University Hospital did not include the Medicare contractual adjustment in third party payments when reporting CICP charges to HCPF. The Medicare contractual adjustment is the difference between the hospital's normal charge for a service and the amount that the federal government has agreed under the Medicare program to pay for the service; in other words, the contractual adjustment is a discount on services that the provider agrees to furnish in order to participate in Medicare. Because the Medicare contractual adjustments were not included in third party payments, the Department did not subtract these adjustments from total charges when calculating write-off charges. In effect, University Hospital billed CICP for the discount it is required to give when providing services under the Medicare program.

University Hospital stated that it has routinely charged the Medicare contractual adjustment to CICP because it represents "uncompensated charges," and the State does not have a policy prohibiting this practice. However, under federal Medicare regulations, Medicare providers are not allowed to bill individuals or other programs, including CICP, for the Medicare contractual adjustment. During our review of Denver Health charges, we found that Denver Health had included the Medicare contractual adjustment with third party payments, and thus, the contractual adjustment was not billed to CICP. Denver Health stated that it was not its policy to bill CICP for the Medicare contractual adjustment.

Upon request, University Hospital reported to us that its Fiscal Year 2000 CICP charges included approximately $6.7 million in Medicare contractual adjustments. Using the Department's method for calculating payments to Component 1A providers, we estimate that this translates into about $2 million (9 percent) of University Hospital's total projected Fiscal Year 2002 reimbursement of $21.7 million in Component 1A payments. As a result, there was $2 million less available to pay other Component 1A providers, since all Component 1A providers are paid from a set pool of funds.

The inconsistencies in reporting contractual adjustments means that providers are not being reimbursed on an equitable basis. In this particular case, the inconsistency is particularly problematic because it results from the provider's lack of compliance with federal regulations. Therefore, we are recommending that the Department adjust University Hospital's Fiscal Year 2002 projected reimbursement to deduct the $2 million derived from the Medicare contractual adjustments not subtracted from CICP charges. In addition, HCPF should work with the Centers for Medicare and Medicaid Services, the federal

agency that oversees both of these programs, to determine additional actions that the Department might need to take with respect to prior year CICP payments to University Hospital.

Formalization of Policies and Use of On-Site Audits

The inconsistency in how the two largest CICP providers handled contractual adjustments occurred for two reasons. First, the Department does not audit charges submitted to the program to the provider's supporting documentation. Hence, HCPF did not have sufficient means to identify this problem and address it. Currently the Department relies on audits performed by providers' external auditors to identify problems related to CICP.

The second reason for this inconsistency is that the Department has not formalized policies regarding how contractual adjustments should be reported to the State to ensure that they are subtracted from total CICP charges. More broadly, the CICP manual does not define "charges." The manual should state that charges should be derived from the provider's billing system and that charges for CICP services should be the same as those charged to other patients receiving the same service during the same period. Although we did not find instances in which providers were billing CICP clients for charges on a basis different from that used for other patients, the problems identified with the contractual adjustments demonstrate the potential for inconsistencies in reporting—and, thus, the basis for reimbursement—when terms and requirements are not clearly defined.

Program staff report that it is the Department's intention that contractual adjustments be included in third party payments. However, this has only been communicated informally, which clearly is not sufficient. The Department should establish policies regarding CICP charges and adjustments to charges and periodically perform on-site testing of charges for those providers that receive significant amounts of reimbursement under CICP, or where other indications of risk exist. While it is reasonable for the Department to use the external audits as one tool to oversee the program, the audits are not a sufficient substitute for the Department itself testing the source data used to determine payments for CICP.

(CDFA Nos. 93.777, 93.778; Medicaid Cluster; Other.)

Recommendation No. 34:

The Department of Health Care Policy and Financing should reduce the projected Fiscal Year 2002 payment for University Hospital to reflect the provider's overbilling of the State related to the Medicare contractual adjustments of approximately $6.7 million. HCPF should work with the Centers for Medicare and Medicaid Services to determine additional actions the State should take as a result of prior overpayments made with Medicaid Disproportionate Share Hospital funds to University Hospital due to Medicare contractual adjustments.

Department of Health Care Policy and Financing Response:

Agree. The Department has requested the necessary data from University Hospital so these adjustments can be made to the figures reported in the Fiscal Year 1999-2000 and Fiscal Year 2000-2001 annual reports and the corresponding projected Fiscal Year 2001-2002 reimbursement will be adjusted. Once this report has been published, the Department will contact the Centers for Medicare and Medicaid Services to determine any potential liability for the State. The Department expects this work to be finalized before July 1, 2002. The Fiscal Year 2002-2003 CICP Manual will further clarify that Medicare contractual adjustments cannot be billed to CICP.

Recommendation No. 35:

The Department of Health Care Policy and Financing should ensure charges submitted for the Colorado Indigent Care Program are consistent with the program's intent and reported on the same basis for all providers by:

a. Developing formal policies regarding the basis for reported charges and how contractual adjustments and other adjustments should be treated.

b. Performing periodic on-site testing of the validity of charges and related adjustments submitted to CICP on the basis of the amount of reimbursement a provider receives and other risk factors.

Department of Health Care Policy and Financing Response:

Agree. The Department will formalize the policies regarding contractual adjustments and other adjustments in the Fiscal Year 2002-2003 CICP Manual that will be issued by July 1, 2002. Currently the Department does not have the funding or the FTE available to perform periodic testing of the validity of charges and related adjustments submitted to CICP. The Department will consider requesting additional resources to perform this function.

Auditor's Addendum

If the decision ultimately is made to continue to reimburse CICP providers primarily on the basis of CICP costs derived from CICP charges (see Recommendation No. 1 in the Colorado Indigent Care Program Performance Audit), the Department must implement controls to ensure the accuracy and appropriateness of those charges, including on-site audits performed on the basis of risk. Without these controls, requesting data on CICP services from providers is not a meaningful requirement.

Documentation and Consistency of Reimbursement Methodology

In addition to testing providers' CICP charges, we reviewed prospective payment calculations for 39 of the 68 CICP providers (57 percent) for Fiscal Year 2002. At the time of our review, these 39 providers were projected to receive almost $83.3 million out of the projected total of $86.7 million in Outstate and Component 1A payments for Fiscal Year 2002. Our sample included 8 Outstate clinics, 22 Outstate hospitals, and all 9 of the Component 1A hospitals.

From a technical viewpoint, we did not identify errors in the calculations of Fiscal Year 2002 payments. However, we identified inconsistencies in how HCPF calculated write-off costs for providers for Fiscal Year 2000. Because these cost data form the basis for calculating Fiscal Year 2002 payments, these inconsistencies have carried forward into current year payments. In addition, HCPF did not obtain documentation from providers to support critical information used in the Fiscal Year 2000 calculations; this could cause errors and lead to other inconsistencies' going undetected. These inconsistencies and lack

of documentation create concerns that provider reimbursements are not being calculated on an equitable basis within each provider category.

Inconsistencies and Lack of Supporting Documentation

As mentioned in the previous section, the Department calculates provider payments by starting with each provider's charges for CICP services and subtracting third party payments and patient liability or copayments. The resulting write-off charges are multiplied by a cost-to-charge ratio, which is the ratio of total facility costs to total facility charges.

By multiplying each provider's CICP write-off charges by the provider's cost-to-charge ratio, the Department converts CICP write-off *charges* to estimated CICP write-off *costs*. This ensures that the provider's CICP payments do not reflect any "profit" for the facility. Cost-to-charge ratios for individual facilities can vary widely; in Fiscal Year 2001, individual hospitals' ratios of their total facility costs compared with total facility charges ranged from 0.31 to 0.98. Clinics that are federally qualified health centers (FQHCs) are mandated under federal regulations to operate on a cost-to-charge ratio of 1:1. Most clinics in CICP are FQHCs—in Fiscal Year 2001, all but 2 of the 17 participating clinics were FQHCs.

The Department determines providers' cost-to-charge ratios using data from federally required documents that each provider submits to the Department annually. By using standard data for the cost-to-charge ratio, the Department intends to ensure that all providers' costs, and therefore their reimbursements, are calculated on an equitable basis. Specifically, each hospital must submit designated information on total facility costs and total facility charges from its Medicare hospital cost report, along with supporting documentation from the report. Each clinic is required to submit information on total facility costs and total facility charges from its Uniform Data System Report, along with supporting documentation. On the annual CICP provider application, the Department informs providers that a facility that wishes to submit anything other than these figures and documentation must submit a written explanation to the Department for approval.

In the course of our audit, we identified the following instances in which the Department either deviated from its stated method for calculating providers' cost-to-charge ratios without adequately documenting the rationale for these exceptions or did not acquire and maintain appropriate supporting documentation for the cost-to-charge ratio. This raises concerns about whether or not payments were calculated on an equitable basis.

- At the request of Denver Health and University Hospital, the Department used costs to calculate these facilities' cost-to-charge ratios that were different from, or in addition to, those required in the CICP provider application. In both cases, the Department did not obtain documentation from the providers that fully substantiated the basis for using the information. HCPF staff indicate that since the providers asked for these changes, the changes probably had a favorable impact on the reimbursements for these providers. However, we found limited evidence that HCPF staff had analyzed the providers' requests. In other words, staff were not clear on the basis for the changes being requested; how the changes would impact the providers' cost-to-charge ratios, in comparison with the standard information requested in the application; and whether the changes were appropriate. In summary, there was no documentation in the files indicating the basis for the Department's decision to use the alternative information furnished by these providers to calculate their cost-to-charge ratios.

  The Department states that in some cases it is appropriate to make adjustments to cost-to-charge ratios based on new information or unique circumstances. While we recognize that there may be instances in which deviations from the standard cost-to-charge methodology may be reasonable, the Department should clearly document the basis for its decision when exceptions are made.

- For hospitals that had observation beds costs, the Department included those costs in "total facility costs," although this is a deviation from HCPF's stated methodology in the provider application for calculating the cost-to-charge ratio. For the 25 hospitals in our sample with observation beds costs, including these costs had a positive impact on reimbursement because it increased their respective cost-to-charge ratios. The Department's reason for including these costs was not documented, and the Department did not notify providers that a change in policy had occurred.

  For Fiscal Year 2000, HCPF's methodology was still to reconcile Outstate providers' estimated CICP costs to actual CICP costs once all data for Fiscal Year 2000 had been submitted. We estimate that the Outstate hospitals in our sample received a total of about $67,000 more in Fiscal Year 2000 due to the inclusion of observation beds costs in their cost-to-charge ratios. This reduced the amount available to other Outstate providers, since providers are paid from a set pool of funds.

  As of Fiscal Year 2002, Outstate providers, like Component 1A providers, will be reimbursed on a prospective basis, which means that no year-end reconciliation

will be performed between estimated and actual CICP costs. Because the Fiscal Year 2000 data are being used as the basis for Fiscal Year 2002 payment calculations, this deviation from policy related to observation beds costs is also incorporated into current year payments. We estimated that the Outstate and Component 1A hospitals' projected payments for Fiscal Year 2002 increased about $89,000 and $87,000, respectively, as a result of this past decision.

Further, in one instance the Department did not include observation beds costs for an Outstate hospital that, in fact, had these costs. If the Department's intent was to include these costs, then this provider was underpaid $2,200 in Fiscal Year 2000. This also translates into a projected underpayment of $2,900 for this provider in Fiscal Year 2002.

- For one Outstate provider, the Department used the cost-to-charge ratio reported by the provider, although the provider had not furnished any documentation to support the reported figures. In another case, the Department used the provider's reported cost-to-charge ratio, although the supporting documentation did not agree with the stated ratio. We did not find evidence that the Department had followed up with either provider to resolve these issues.

Additionally, we noted that the Department relies on data from Medicare cost reports that have not yet been audited as the basis for the cost-to-charge ratios. The Department already has a contractual relationship with one of the Medicare intermediaries for the Medicare program in the State. The Medicare intermediary is responsible for auditing providers' Medicare cost reports. By expanding that contract or entering into an additional one, HCPF could obtain audited data for the cost-to-charge ratios and thus ensure greater reliability and consistency of these numbers as well as greater equity in calculating provider payments.

Formalization of the Reimbursement Process

Overall, the Department needs to formalize its reimbursement process in order to demonstrate that it is treating providers equitably. Many of these issues could be addressed by the Department's formalizing its policies with respect to the reimbursement process and following through when documentation is lacking or inadequate. In addition, the Department's policies related to reimbursement calculations should be clearly stated and communicated to providers. Finally, HCPF should base cost-to-charge ratios for providers on audited data.

(CDFA Nos. 93.777, 93.778; Medicaid Cluster; Other.)

Recommendation No. 36:

The Department of Health Care Policy and Financing should develop and implement controls over the reimbursement process for the Colorado Indigent Care Program by:

a. Applying the reimbursement methodology consistently to all providers within each CICP provider category and documenting the reasons for any exceptions from the standard methodology in the provider's file.

b. Obtaining audited information on which to base providers' cost-to-charge ratios.

c. Requiring in instances where audited information is not available that providers submit all necessary supporting documentation for calculating cost-to-charge ratios, reviewing this documentation for errors or problems and following up as appropriate, and maintaining all cost-to-charge ratio documentation in the provider's file.

d. Informing providers about all policies and procedures related to determining provider reimbursements.

Department of Health Care Policy and Finance Response:

Agree. The Department will examine the current controls over the reimbursement process and implement new procedures as necessary. The Department will maintain more documentation regarding this information and provide more information to affected providers. The Department will consider creating a separate contract with an outside entity to provide consistent audited information on which to base providers' cost-to-charge ratios. The Department will implement the procedures for making adjustments by October 31, 2002, so the information will be included with the final Fiscal Year 2001-2002 cost data submitted by CICP providers.

Ensuring Certified Expenditures Are Appropriate

Our audit examined the Department's process for overseeing the certification of public expenditures by public hospitals in CICP. During Fiscal Year 1998, the State began to use certified expenditures made by some of these facilities as the basis for drawing down federal funds in place of spending state general funds. In Fiscal Year 2001, Denver Health Medical Center (Denver Health) and the University of Colorado Hospital (University Hospital) together certified about $165.9 million in expenditures to the State. In turn, on the basis of these certified amounts, the Department drew about $83 million in federal funds, which the State then paid to these two providers.

Certification has significantly decreased the use of general funds for CICP, thereby freeing up funds for other purposes. The Department is awaiting approval from the federal Centers for Medicare and Medicaid Services (CMS) for a new amendment to the State Plan that would extend the use of certification to 18 public hospitals in the Outstate hospital category. If approved, this will further decrease the use of state general funds for CICP.

While the use of certified expenditures has obvious advantages for the State, it also presents some risks because the State is relying on information from other entities as the basis for drawing federal funds. Because the State is the entity actually drawing these funds—and the entity statutorily responsible for oversight of the Medicaid program for the State—the Department needs to ensure expenditures certified by other entities are appropriate. We reviewed the Department's procedures for certification and concluded that HCPF should implement reconciliations to ensure that certified expenditures, which are based on cost estimates, are supported by actual costs.

Comparison of Certified Expenditures to Actual Costs Incurred

The Department notifies Denver Health and University Hospital at the beginning of the fiscal year of the amount of public expenditures each hospital will need to certify quarterly in order for the State to draw the necessary federal funds to make the projected payments for the year to these facilities. The Department also furnishes the wording that providers are to use in the letters sent to HCPF to document their quarterly certification of expenditures. The Department maintains a worksheet to track receipt of the letters and the amounts certified. Staff indicate that the purpose of the certification letters is to have the supporting documentation from the providers for the expenditures, since these expenditures

are the basis for the federal draws. The Department determines the amount of expenditures to be certified by Denver Health and by University Hospital annually on the basis of the projected payments each facility is to receive for the fiscal year.

To ensure that certified expenditures were not excessive, we compared the amounts certified by Denver Health and University Hospital for Fiscal Years 2000 and 2001 with actual CICP write-off costs for those years. For Denver Health, we did not identify instances in which certified Component 1A costs were greater than actual write-off costs for either year. In the case of University Hospital, we did not identify problems with amounts certified for Component 1A payments for Fiscal Year 2000. However, in Fiscal Year 2001, University Hospital certified Component 1A costs that *exceeded* actual write-off costs by $1.8 million. In other words, the certified amounts the Department used to draw down federal funds for University Hospital's Component 1A payments were greater than University Hospital's actual CICP costs in Fiscal Year 2001. Under the Medicaid program, the federal government will reimburse half of qualifying expenditures or costs. This means that the Department's draw of about $900,000 (50 percent of the $1.8 million) in federal funds was based on estimated costs not supported by actual expenditures made by University Hospital.

HCPF staff state that the federal government has approved the Department's methodology for using estimated costs as the basis for calculating payments to Component 1A providers and is aware that the Department uses certification as the basis for drawing the federal funds used for paying Denver Health and University Hospital. Therefore, staff indicate that HCPF need not perform a reconciliation between estimated and actual costs and that, in fact, such a reconciliation is exactly what the prospective payment method was created to avoid. The prospective payment method was adopted because of the problems that performing year-end reconciliations caused with budgeting and the impact on other providers' payments, since all providers are paid from one pool of funds. Accordingly, HCPF staff do not believe it is necessary to ensure that certified expenditures do not exceed actual costs for a specific fiscal year. Additionally, staff point out that public providers have additional qualifying expenditures under the bad debt amendment to the State Plan, and any shortfall in certifiable expenditures under the Component 1A amendment could easily be made up by certifying additional bad debt costs.

Under federal regulations, federal reimbursements must be based on actual expenditures. Therefore, we believe that amounts certified as public expenditures based on estimates under Component 1A must be reconciled to actual costs as defined in the State Plan under that amendment to ensure that certified amounts are at least equal to actual expenditures. With respect to substituting bad debt costs for any shortfall in certifiable CICP costs under the Component 1A amendment, this would require that the Department mix the sources

of certified expenditures between two different State Plan amendments. The Department should confirm with the federal Centers for Medicare and Medicaid Services that this is an acceptable remedy. In any case, without formally reconciling certified amounts based on estimated costs and actual costs for Component 1A, the Department could not be assured that it would identify shortfalls in actual costs.

Receipt of Other Federal Funds

The Department should also ensure that public hospitals are aware that certified expenditures are used by the State as the basis for drawing federal funds, especially as HCPF asks more hospitals to certify their CICP costs as public expenditures. In particular, providers need to be aware that federal regulations prohibit the same expenditure from being reimbursed under two different federal programs. In other words, the hospitals cannot certify expenditures to the State for CICP that are reimbursed by other federal funds, either in whole or in part.

We found that the language provided by the Department and used by the hospitals to certify expenditures does not require that the hospital provide assurance that it did not receive any other federal funds as reimbursement for these expenditures. The Department should incorporate such language into the format given to providers for quarterly certification letters to avoid any misunderstanding and possible improper certification of expenditures.

(CDFA Nos. 93.777, 93.778; Medicaid Cluster; Other.)

Recommendation No. 37:

The Department of Health Care Policy and Financing should improve controls over the certification process for the Colorado Indigent Care Program by:

a. Formally documenting annual comparisons of certified public expenditures by each provider to the provider's actual CICP write-off costs for each applicable fiscal year for Component 1A. Similar reconciliations should be done for any future State Plan amendments in which certification is based on estimated costs.

b. Obtaining confirmation from the federal Centers for Medicare and Medicaid Services on whether shortfalls in certified expenditures under Component 1A may be offset by excess certifiable expenditures under a different amendment to the State Plan. If this

is not acceptable, the Department should make the necessary adjustments in federal draws to offset excess amounts received.

c. Informing providers of the purpose of certification and that expenditures cannot be certified if they are reimbursed by other federal funds.

d. Requiring that providers include an assurance in each quarterly certification letter stating that no federal funds were received as reimbursement for the certified expenditures, other than those through CICP.

Department of Health Care Policy and Financing Response:

Partially agree. The Department does not plan to formally document annual comparisons of certified public expenditures to each provider's actual write-off costs. The federally approved prospective payment system used by the Department is designed to be an estimate and is not intended to be reconciled to actual. Increases or decreases in actual costs will impact CICP payments two years in the future. The Department will contact CMS regarding shortfalls from one State Plan amendment to another. The Department will inform providers that expenditures cannot be certified if they are reimbursed by other federal funds and require that providers include an assurance in the certification letters that no federal funds other than those from CICP were received as reimbursement for the certified expenditures. The Department will implement policy clarifications by July 1, 2002.

Department of Higher Education

Introduction

The Department of Higher Education was established under Section 24-1-114, C.R.S., and includes all public higher education institutions in the State. It also includes the Auraria Higher Education Center, the Colorado Commission on Higher Education, the Colorado Council on the Arts, the Colorado Student Loan Division, the Colorado Student Obligation Bond Authority, the Colorado Historical Society, and the Division of Private Occupational Schools. Please refer to page 33 in the Financial Statement Findings section for additional background information.

Board of Regents of the University of Colorado - University of Colorado

The University of Colorado was established on November 7, 1861, by an Act of the Territorial Government. Upon the admission of Colorado into the Union in 1876, the University was declared an institution of the State of Colorado, and the Board of Regents was established under the State Constitution as its governing authority.

The University consists of a central administration and four campuses: Boulder, Denver, Colorado Springs, and Health Sciences Center. These four campuses comprise 16 schools and colleges.

The following comments were prepared by the public accounting firm of Deloitte & Touche LLP, who performed audit work at the University of Colorado.

Student Loan Reconciliation Procedures

The University of Colorado Health Sciences Center (HSC) campus utilizes a loan servicer to invoice, collect amounts due, and maintain individual student loan balances. When student loans are disbursed from the Office of Financial Aid, initial loan balances are posted to the HSC's Student Information System (SIS) within the general ledger. On a weekly basis the loan servicer receives a batch update from HSC that includes all new and updated student data included in SIS since the previous update. When the student goes

into repayment status, upon graduation or leaving school, the loan servicer will then invoice the student and collect the loan payments. All monthly transactions managed by the loan servicer are provided back to HSC and posted to the general ledger on a monthly basis. As of June 30, 2002, the loan servicer managed 4,368 loan accounts, approximating $12.2 million, from current and former students.

Each term, the HSC Bursar's Office reconciles the records of graduating students to ensure that the manual student loan file, the student loan activity included in SIS, and the loan servicer information are complete and accurate. Our review of seven student loan files revealed that two manual student loan files did not agree with the information in SIS or the loan servicer's records. In one case, a student's loan balance maintained by the loan servicer was overstated by $2,813, or 25 percent. This resulted in the student's being invoiced more than required by the loan agreement. In another case, the required signed promissory notes were not included in the manual student file maintained by HSC.

In May 2001 the management of the HSC Bursar's Office changed. The new Bursar identified many reconciling items and issues early in the management of his office. In addition, new student loans that were initiated during the Fiscal Years 2000 and 2001 were fully reconciled in February 2002. During this reconciliation, corrections were made to the information sent to the loan servicer and to the general ledger. We reviewed HSC's monthly reconciliations between the loan servicer's records and the general ledger and noted many items remaining on the reconciliations that were greater than six months old.

While informal controls have been established, they need to be strengthened and documented. Controls are more likely to be consistently and appropriately applied when they are formalized into written policies and procedures, clearly communicated to staff, and periodically reviewed to ensure they are being followed. This will provide assurance that student loan information maintained at both HSC and the loan servicer is complete and accurate.

(CFDA Nos. 84.038, 84.268, 93.342, 93.364; Federal Perkins Loan Program, Federal Direct Student Loans, Health Professions Student Loans, Nursing Student Loans; Other.)

Recommendation No. 38:

The University of Colorado Health Sciences Center (HSC) should strengthen controls over the student reconciliation process. Specifically:

a. Controls should be formalized into written policies and procedures, and should be clearly communicated to the HSC Bursar's Office staff.

b. Controls should be periodically reviewed to ensure they are being followed consistently and appropriately.

c. The HSC Office of the Bursar should work to clear outstanding reconciling items between the Student Information System, the loan servicer, and the general ledger on a timelier basis.

University of Colorado Health Sciences Center Response:

Agree. The University of Colorado Health Sciences Center (HSC) plans to continue to enhance the management of the student loan process. Specifically, the HSC Bursar's Office has begun a formal reconciliation between the Student Information System and the loan servicer on a monthly basis and will formalize written policies and procedures for the student loan reconciliation process by December 31, 2002. In addition, the HSC Bursar's Office will reconcile every loan balance on the loan servicer's system by December 31, 2002. It should also be noted that the loan balance for the one student with a 25 percent overstated loan balance has been adjusted to the correct balance. Based on our review to date, no student has ever overpaid his or her loan balance as a result of this problem.

State Board of Agriculture

The State Board of Agriculture has control and supervision of three distinct institutions: Colorado State University, a land-grant university; Fort Lewis College, a liberal arts college; and the University of Southern Colorado, a regional university with a polytechnic emphasis. Effective September 1, 2002, Fort Lewis College will no longer be part of the Colorado State University System.

The Board administers the State Board of Agriculture Fund located in the State Treasury. The Board is authorized to fix tuition, pay expenses, and hire officials. The chief academic and administrative officers are the chancellor of the Colorado State University System and the president of each institution.

Colorado State University

Colorado State University was originally created in 1870 as the Agricultural College of Colorado. In 1876 when Colorado became a state, it was placed under the governance of the State Board of Agriculture, and began admitting students in 1879. It was also designated that year as Colorado's land-grant college and recipient of federal endowment support under the Morrill Act of 1862. Subsequent federal legislation led to the establishment of the Agricultural Experiment Station and the Cooperative Extension Service of the University. State legislation also made the University responsible for the Colorado State Forest Service. Following several name changes, the College became Colorado State University in 1957.

The following was prepared by the public accounting firm of Clifton Gunderson, LLP, who performed audit work at Colorado State University.

Fire Management Assistance Grant

During Fiscal Year 2002 the Federal Emergency Management Agency (FEMA) awarded a $20 million grant through the Colorado Office of Emergency Management (OEM) to Colorado State University (Colorado State Forest Service) for aiding fire-fighting efforts across the State. The costs related to the Fire Management Assistance Grant were incurred primarily during May, June, and July 2002 at 14 general locations. Subsequently, FEMA issued 14 direct grant awards to the Colorado State Forest Service in July 2002 to replace the original grant awarded through the Colorado Office of Emergency Management. Accordingly, the original pass-through grant from FEMA of $20 million was eliminated in September 2002. The University recorded $16.8 million of expenses in its accounting records for costs incurred through June 30, 2002. Of the $16.8 million of expenses, the Colorado State Forest Service drew down $12.8 million after June 30, 2002, which represents only a portion of the total costs considered reimbursable from FEMA.

The University is responsible for complying with applicable federal laws, rules, and regulations for federal funds received under the FEMA grant. Because this grant met the requirements for audit under the Office of Management and Budget (OMB) Circular A-133 during Fiscal Year 2002, we attempted to determine the University's compliance with federal requirements. We encountered several problems and limitations to performing the necessary compliance testing for the grant for Fiscal Year 2002:

- Allowability of Costs: The June 30, 2002, accrual of $12.8 million in reimbursable expenditures was based on estimates developed by the Colorado State Forest Service in conjunction with FEMA. As of November 7, 2002, the University had

received about $5 million of actual billings from local governments and other entities, which is about 40 percent of the reimbursable amount. Therefore, documentation supporting a significant amount of the reimbursable expenditures (60 percent) was not available for testing at the completion of our audit. The Colorado State Forest Service stated that it does not expect to receive all the remaining billings for another two to three months, or possibly longer.

- Cash Management: The University did not receive any advances of federal funds during State Fiscal Year 2002. FEMA did advance the University $12.8 million during Fiscal Year 2003. In addition, the Colorado State Forest Service must substantiate the $12.8 million of expenses before receiving any additional funding it may be eligible for under the grants. Thus, we could not test cash management controls during the year under audit and would need to test such controls during the following fiscal year (Fiscal Year 2003).

- Reporting Requirements: The performance periods for the grants end between January and May 2003. The performance periods could be extended another three months if needed. The University must then file Financial Status reports reflecting all costs incurred during the incidence periods and all administrative costs incurred during the performance periods. Consequently, these reports will likely not be available for testing until June 2003, which is near the end of the State Fiscal Year 2003.

Because of the above limitations, we were unable to adequately test the primary compliance requirements for the grants during our Fiscal Year 2002 audit. Therefore, we will test compliance for both State Fiscal Years 2002 and 2003 during the Fiscal Year 2003 audit.

(CFDA No. 83.556; Fire Management Assistance Grant; Allowability of Costs, Cash Management, Reporting Requirements.)

No recommendation is made in this area.

University of Southern Colorado

The University of Southern Colorado was incorporated in 1935. On July 1, 1975, the State Legislature granted the institution university status. Three years later, the Colorado State Board of Agriculture assumed governance of the University. The University of Southern Colorado is accredited at the bachelor's and master's levels, with special emphasis on polytechnic education. Effective July 1, 2003, the University of Southern Colorado will become Colorado State University - Pueblo. The institution’s role and

mission will change from that of a "general baccalaureate and polytechnic institution" to being a "regional, comprehensive university."

The following comment was prepared by the public accounting firm of Grant Thornton, LLP, who performed audit work at the University of Southern Colorado.

Federal Perkins Loan Program

Federal Perkins loans are available to certain students meeting eligibility requirements established by the United States Department of Education. The loan program is partially funded by the federal Department of Education. The Department of Education requires certain procedures to be followed by all institutions accepting Federal Perkins Loan Program funds including, but not limited to, (1) maintaining certain documentation in individual files for each borrower, (2) managing a revolving loan fund for the Program that includes the collection of loan payments, and (3) submitting data on borrowers to the National Student Loan Data System on a timely basis. If these procedures are not followed, the University risks losing these federal funds to support student attendance.

Our audit included testing the University's compliance with the Perkins Loan Program requirements. We noted the following areas for improvement:

- Borrowers under the Federal Perkins Loan Program may be eligible for loan deferments or cancellations under certain circumstances as outlined in the Federal Perkins Loan Program guidelines. Our audit procedures included testing 10 borrowers who had their loans deferred or canceled during the fiscal year ended June 30, 2002. The tests determined whether appropriate documentation existed in the student loan files regarding the deferment or cancellation. For 3 out of 10 borrowers who had their loans deferred or canceled, the University obtained signed statements from borrowers indicating financial hardship. However, the students' files did not contain adequate documentation supporting the financial hardship as required by University policies and procedures and federal guidelines.

- Loans under the Federal Perkins Loan Program, including accrued interest, are repayable in equal or graduated periodic installments in amounts calculated on a 10-year repayment period. The lending institution is required to establish a repayment plan for the borrower in accordance with federal guidelines. Our audit procedures included testing the timely conversion of a student loan to repayment status for 10 students who withdrew from the University or dropped below half-time status during the year. For 10 out of 10 students, the University's system incorrectly calculated the date that the student loan was placed into repayment status. Federal guidelines require a loan to be converted to repayment status nine

months after a student ceases to be at least a half-time student. The University's system automatically calculates the date the loan converts to repayment status as the 15th day of the month following the date the student actually withdraws or becomes less than a half-time student rather than on the nine-month anniversary date. As a result, the date that a loan converts to repayment status in the system may be anywhere from 1 day to 30 days late. Accordingly, the University is not charging interest for the interim period between the withdrawal date and the system's calculated repayment date.

- When a student withdraws from the University, he or she is required to notify the University's Admissions Department, Student Financial Aid Department, and Records Department by providing each department with a copy of a signed withdrawal form. When the Records Department receives the withdrawal form, the Department is required to transmit withdrawal information to the National Student Loan Data System in order to ensure that the student's loan database information is current for use by lenders and other universities. Our audit procedures included testing 10 students who withdrew from the University during the year to determine that withdrawal information was appropriately transmitted to the National Student Loan Data System. For 1 of 10 students, withdrawal information was not transmitted to the National Student Loan Data System, resulting in an incorrect student status within the national database.

(CFDA No. 84.038; Federal Perkins Loan Program; Special Tests and Provisions.)

Recommendation No. 39:

The University of Southern Colorado should for the Federal Perkins Loan Program:

a. Strengthen procedures to ensure that adequate documentation is obtained from borrowers to support financial hardship for deferment or cancellation of student loans.

b. Modify its loan collection program to ensure that the calculation of the date a student loan enters repayment status is in accordance with federal guidelines.

c. Strengthen procedures to ensure that student withdrawal information is reported to the National Student Loan Data System for all students.

University of Southern Colorado Response:

Agree. The University of Southern Colorado has made significant improvements in the management of the Federal Perkins Loan Program in the past fiscal year, and further improvements are planned:

a. A supervisor will review and approve on all documentation from borrowers requesting a financial hardship deferment of their Federal Perkins Loan. To be implemented November 2002.

b. This is a function of the software used to manage the Perkins program. We will review federal requirements applicable to the Perkins Loan Program. To be implemented March 2003.

c. The University will work to strengthen the process with other University departments to ensure all student withdrawals are transmitted to the National Student Loan Data System. To be implemented January 2003.

State Board for Colorado Community Colleges and Occupational Education

The State Board for Community Colleges and Occupational Education (SBCCOE or the Board) was established by the Community College and Occupational Education Act of 1967, or Article 23-60, C.R.S. The Board functions as a separate entity and, as such, may hold money, land, or other property for any educational institution under its jurisdiction. The statute assigns responsibility and authority to the Board for three major functions:

- The Board is the governing board of the state system of community and technical colleges.

- The Board administers the occupational education programs of the State at both secondary and post-secondary levels.

- The Board administers the State's program of appropriations to local district colleges and area vocational schools.

The Board consists of nine members appointed by the Governor to four-year staggered terms of service. The statute requires that Board members be selected to represent certain economic, political, and geographical constituencies.

The thirteen colleges in the community college system are as follows:

College	Main Campus Location
Arapahoe Community College	Littleton
Community College of Aurora	Aurora
Community College of Denver	Denver
Colorado Northwestern Community College	Rangely
Front Range Community College	Westminster
Lamar Community College	Lamar
Morgan Community College	Fort Morgan
Northeastern Junior College	Sterling
Otero Junior College	La Junta
Pikes Peak Community College	Colorado Springs
Pueblo Community College	Pueblo
Red Rocks Community College	Lakewood
Trinidad State Junior College	Trinidad

The following comments were prepared by the public accounting firm of KPMG LLP, who performed audit work at the Colorado Community College System.

Student Financial Assistance

We performed procedures on Student Financial Assistance (SFA) required by the Office of Management and Budget (OMB) Circular A-133 and the Compliance Supplement for Student Financial Aid. We also performed procedures as required by the *Colorado Handbook for State-Funded Student Financial Assistance Programs*, issued by the

Colorado Commission on Higher Education (CCHE), 2002 revision. The 13 findings and recommendations below result from this work and are presented in the format required under OMB Circular A-133 and *Government Auditing Standards*.

Student Financial Assistance Professional Judgments

A financial aid administrator (FAA) may use professional judgment, based on adequate documentation and on a case-by-case basis, to either increase or decrease one or more of the data elements used to calculate an estimated family contribution (EFC) or to adjust a student's cost of attendance (COA). The reason must be documented in the student's file, and it must relate to that student's special circumstances that differentiate the individual student (not to conditions that exist for a whole class of students). A school must maintain records for each SFA recipient that include, but are not limited to, documentation of all professional judgment decisions. Moreover, a school's recordkeeping procedures should allow for establishing and maintaining a clear audit trail. A clear audit trail is defined as maintaining required documentation that supports each transaction involving receiving or expending federal funds. (*2001 - 2002 United States Department of Education Application and Verification Guide; 2001 - 2002 United States Department of Education Student Financial Aid Handbook, Volume 2: Institutional Eligibility and Participation, Chapter 8: Recordkeeping and Disclosure; June 2001 United States Department of Education Blue Book, Chapter 2: General Institutional Responsibilities.)*

Adequate procedures are not in place at Pikes Peak Community College (PPCC) to ensure that professional judgments are made in accordance with the supporting documentation provided by the student. In a sample of 30 students (8 from PPCC), 2 of the PPCC students selected had inadequately documented professional judgments that changed their EFC. The changes were not supported by the documentation provided. The students were awarded SFA based on the newly calculated EFCs. Upon presentation of this situation to the Registrar/Director of Enrollment Services, who concurred that the documentation did not support the changes made, the professional judgments were redone, resulting in new EFCs. The resulting Pell awards were $2,250 less than the originally paid Pell awards. The original Pell over-awards were replaced by state aid, leaving the students with the same total aid packages. The effect of the finding is that PPCC may make professional judgments that are not based on the supporting documentation, which, if not detected and corrected, could result in SFA awards being made to ineligible students or at improper award levels.

This finding resulted in questioned costs of $2,250. These charges were originally made to the federal Pell program and then subsequently credited to the federal Pell program, being covered by institutional funds, following discovery during the audit.

(CFDA No. 84.063; Federal Pell Grant Program; Eligibility.)

Recommendation No. 40:

Pikes Peak Community College should establish procedures to ensure that professional judgments are clearly based on the supporting documentation received from the students and that the professional judgments are adequately documented, providing a clear audit trail.

Pikes Peak Community College Response:

Agree. Pikes Peak Community College agrees and will provide focused training for all financial aid officers to reinforce the need for a clear audit trail by June 2003.

Federal Direct Loans

Front Range Community College (FRCC) does not have adequate procedures in place to ensure that spring graduate Federal Direct Loan borrowers receive written exit counseling materials in a timely manner. Front Range Community College and Trinidad State Junior College (TSJC) do not have adequate procedures to ensure that exit counseling is provided to borrowers who cease at least half-time attendance.

In a sample of 30 students (7 from FRCC and 3 from TSJC), there was one FRCC student who separated from the College by graduating in May for whom the College did not have documentation substantiating the student's compliance with exit counseling regulations. At FRCC, exit counseling materials are mailed at the end of summer term to spring and summer graduates. Therefore, the school did not advise this student, or any of its other spring graduate borrowers, to complete exit counseling shortly before graduating, and exit counseling materials were not mailed to this student, or any of the other spring graduate borrowers, within 30 days of graduation, as required by the regulations. In addition, TSJC and FRCC do not monitor borrowers who cease at least half-time attendance; therefore, these borrowers do not receive exit counseling unless they graduate. Exit counseling is not being provided timely to spring graduate Federal Direct Loan

borrowers at FRCC. Exit counseling is not being provided to Stafford Loan borrowers at FRCC and TSJC who cease at least half-time attendance.

A school should advise its Stafford Loan borrowers to sign up for an exit counseling session or complete online exit counseling before the student borrower ceases at least half-time attendance or graduates. If the student fails to complete the exit counseling as required, the school must provide exit counseling either through interactive electronic means or by mailing written exit counseling materials to the student borrower within 30 days after the school learns that the student borrower has withdrawn from school or failed to complete exit counseling as required. A school must maintain documentation substantiating their compliance with exit counseling for each student borrower. *(34 CFR 682.604 - FFEL; 34 CFR 685.304 - FDL.)*

(CFDA Nos. 84.032 and 84.268; Federal Family Education Loans and Federal Direct Student Loans; Special Tests.)

Recommendation No. 41:

Front Range Community College should establish procedures to ensure that all graduating Federal Direct Loan borrowers who do not complete exit counseling before graduating receive written exit counseling materials within 30 days following their graduation. Front Range Community College and Trinidad State Junior College should establish procedures to ensure that exit counseling is provided to borrowers who cease at least half-time attendance.

Front Range Community College and Trinidad State Junior College Response:

Agree. Front Range Community College and Trinidad State Junior College agree and will implement the necessary changes no later than June 30, 2003.

Determination of Withdrawal Date

A school is required to determine the withdrawal date for a student who withdraws without providing notification by 30 days after the end of the term from which the student withdrew. Further, the school must return its portion of unearned Title IV funds by no later than 30 days after the date the school determined the student withdrew. *(34 CFR 668.22.)*

Adequate procedures are not in place at Trinidad State Junior College (TSJC) to ensure that the withdrawal date of students who withdraw without providing notification is determined within 30 days after the end of the term. In a sample of 30 students (3 from TSJC), there was a TSJC student who unofficially withdrew in the fall 2001 semester, but the withdrawal date was not determined until April 15, 2002. The return of unearned funds was then made on April 16, 2002. The latest date by which this student's withdrawal date should have been determined was January 12, 2002, and the return of unearned Title IV funds should have been made by February 11, 2002.

Withdrawal dates for students who unofficially withdraw from TSJC are not being determined timely. This in turn has caused TSJC to return its portion of unearned Title IV funds, in our sample totaling $500, beyond the time frame established by the regulations.

(CFDA No. 84.063; Federal Pell Grant Program; Special Tests.)

Recommendation No. 42:

Trinidad State Junior College should establish procedures to ensure that the withdrawal dates of students who withdraw without providing notification are determined at the latest within 30 days after the end of the term.

Trinidad State Junior College Response:

Agree. Trinidad State Junior College agrees and will implement by June 2003.

Return of Title IV Funds - Withdrawals

Adequate procedures are not in place at Front Range Community College (FRCC) to ensure that returns are made within 30 days after the date the school determined the student withdrew. A school is required to return unearned Title IV funds no later than 30 days after the date the school determined the student withdrew *(34 CFR 668.22.)*

In a sample of 30 students (7 from FRCC), there were 2 FRCC students for whom returns of Title IV funds were made after the 30-day time period allowed. One return was made 40 days late (or 70 days after the school determined the student had withdrawn) and one return was made 60 days late (or 90 days after the school determined the student had withdrawn). As a result, FRCC returned $1,168 late and was not compliant with

applicable regulations. FRCC has returned its portion of unearned Title IV funds beyond the time frame established by the regulations.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Special Tests.)

Recommendation No. 43:

Front Range Community College should establish procedures to ensure that the institution's portion of a student's unearned Title IV funds are returned within 30 days after the school has determined a student has withdrawn.

Front Range Community College Response:

Agree. Front Range Community College agrees and will implement the necessary changes no later than June 30, 2003.

Overpayments

If a student owes a grant overpayment as a result of a withdrawal, the student is not required to repay the grant overpayment if the initial amount of the grant overpayment, before the 50 percent grant return reduction afforded to students, is less than $25. (*2001 - 2002 United States Department of Education Student Financial Aid Handbook, Volume 2: Institutional Eligibility and Participation, Chapter 6: Return of Title IV Funds)*

Adequate procedures are not in place at Front Range Community College- Westminster (FRCC-W) to ensure that grant overpayments less than $25 after the 50 percent reduction, but greater than or equal to $25 before the 50 percent reduction, are requested to be repaid by the student. In a sample of 30 students (4 selected specifically from FRCC-W), one of the FRCC students owed a grant overpayment that was $25 before the 50 percent reduction, but the College did not request the student to make the return.

FRCC-W did not request the student to repay a required grant overpayment until we questioned costs of $12.50. The College subsequently requested the student repay these funds, which the student has done.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Special Tests.)

Recommendation No. 44:

Front Range Community College - Westminster should establish procedures to ensure students are requested to repay required grant overpayments.

Front Range Community College - Westminster Response:

Agree. Front Range Community College - Westminster agrees and will implement the necessary changes no later than June 30, 2003.

Return of Title IV Funds Calculation - School Portion

If a recipient of Student Financial Aid (SFA) grant or loan funds withdraws from a school after beginning attendance, the amount of SFA grant or loan assistance earned by the student must be determined by calculating a Return of Title IV Funds. If the amount disbursed to the student is greater than the amount the student earned, unearned funds must be returned. The school must return the lesser of (1) the amount of Title IV funds that the student does not earn or (2) the amount of institutional charges that the student incurred for the payment period or period of enrollment multiplied by the percentage of funds that was not earned. If the school returns amount (2), then the student must return the difference between the amount of unearned Title IV funds and amount (2). *(34 CFR 668.22.)*

Adequate procedures are not in place at the Community College of Denver (CCD) to properly calculate Return of Title IV Funds and to make the returns. In a sample of 30 students (6 from CCD), 6 CCD Return of Title IV Funds calculations were performed incorrectly and the resulting returns of unearned aid were not made by the school. Additionally, the school requested the students to return $1,628 more than they were required to return. In summary, the College erroneously calculated the percentage of Title IV funds unearned by the students, improperly excluded spring break, did not make the actual returns, and requested the students to return more than required. CCD's Return of Title IV Funds calculations were incorrect; the amounts they requested the students to return were all higher than they should have been; and the school did not return its portion of the unearned aid.

The finding resulted in questioned costs of $2,278 not returned. Likely questioned costs exceed $10,000 based on indications made by the financial aid director that no returns were likely made for the entire award year.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Special Tests.)

Recommendation No. 45:

Community College of Denver should establish procedures to ensure that Return of Title IV Funds calculations are made properly and to ensure that the school's portion of the unearned aid is returned. This should include a review of all Title IV Funds calculations during the period in question. Errors should be corrected and appropriate action taken.

Community College of Denver Response:

Agree. Community College of Denver agrees and will implement by June 2003.

Return of Title IV Funds Calculation - Institutional Charges

In a Return of Title IV Funds calculation, the school must return the lesser of (1) the amount of Title IV funds that the student does not earn or (2) the amount of institutional charges that the student incurred for the payment period or period of enrollment multiplied by the percentage of funds that was not earned. Institutional charges are tuition, fees, and other education-related expenses assessed by the institution. *(34 CFR 668.22.)*

Adequate procedures are not in place at Front Range Community College (FRCC) to ensure that the proper institutional charges are used. In a sample of 30 students (7 from FRCC), seven institutional charges that are components of the Return of Title IV Funds calculations were based on student budgets rather than on charges that were initially assessed to the student for the payment period or period of enrollment at FRCC.

The calculated amounts of Title IV funds to be returned by FRCC and its students were affected by this improper use of student budgets instead of charges actually assessed the student for the institutional charges portion of the Return of Title IV Funds calculations. The College returned $393 more than required and the students returned less than required, with the net effect being an overreturn. There are no questioned costs, because FRCC

returned $393 more than was required to the Title IV programs, due to the use of incorrect institutional charges in the calculations.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Special Tests.)

Recommendation No. 46:

Front Range Community College should establish procedures to ensure that the proper institutional charges are used in the Return of Title IV Funds calculations.

Front Range Community College Response:

Agree. Front Range Community College agrees and will implement the necessary changes no later than June 30, 2003.

Return of Title IV Funds Calculation - Spring Break Exclusion

Institutionally scheduled school day breaks of five or more consecutive days are excluded from the total number of calendar days in the term in Return of Title IV Funds calculations and therefore do not affect the calculation of the amount of Title IV aid earned. This provides for more equitable treatment of students who withdraw near each end of a scheduled break. All days between the last scheduled day of classes before a scheduled break and the first day classes resume are excluded from both the numerator and denominator in calculating the percentage of the term completed. *(34 CFR 668.22; 2001 - 2002 United States Department of Education Student Financial Aid Handbook, Volume 2: Institutional Eligibility and Participation, Chapter 6: Return of Title IV Funds)*

Adequate procedures are not in place at Community College of Denver (CCD), Pikes Peak Community College (PPCC), Pueblo Community College (PCC), and Front Range Community College - Larimer (FRCC-L) to ensure that spring break, an institutionally scheduled school day break of five or more consecutive days, is properly excluded from the Return of Title IV Funds calculations. In a sample of 30 students (23 from CCD, PPCC, PCC, and FRCC-L), there were 3 CCD students, 2 PPCC students, 1 PCC student, and 1 FRCC student for whom spring break was improperly excluded, which affected the Return of Title IV Funds calculation.

CCD, PPCC, PCC, and FRCC-L improperly excluded spring break in their Return of Title IV Funds calculations, causing $1,266 more to be returned to the Title IV programs than was required. There are no questioned costs, because PPCC, PCC, and FRCC-L returned more than was required to the Title IV programs, since they had more days in the spring term than they should have had in their Return of Title IV Funds calculations. CCD did not return any of its portion of unearned Title IV funds.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Special Tests.)

Recommendation No. 47:

Community College of Denver, Pikes Peak Community College, Pueblo Community College, and Front Range Community College - Larimer should establish procedures to ensure that Spring Break is properly excluded from the Return of Title IV Funds calculations.

Community College of Denver Response:

Agree. Community College of Denver agrees and will implement by June 2003.

Pikes Peak Community College Response:

Agree. Pikes Peak Community College agrees with the recommendation and will require that a second level review for Spring Break calculations is made to ensure funds in excess of that required by the calculations are not returned to the Title IV programs by June 2003.

Pueblo Community College Response:

Agree. Pueblo Community College agrees with the recommendation and will implement necessary changes no later than June 30, 2003.

Front Range Community College - Larimer Response:

Agree. Front Range Community College - Larimer agrees and will implement the necessary changes no later than June 30, 2003.

Eligibility Certification Approval Report

The Eligibility Certification Approval Report (ECAR) must be kept available for review by auditors. The ECAR contains the most critical data elements that form the basis of the school's approval for participating in the Student Financial Aid (SFA) programs, such as the SFA programs the school is eligible to participate in, the highest level of programs offered, any non-degree programs or short-term programs, and any additional locations that have been approved for the SFA programs. *(2001 - 2002 United States Department of Education Student Financial Aid Handbook, Volume 2: Institutional Eligibility and Participation, Chapter 10: Applying for and Maintaining Participation; June 2001 United States Department of Education Blue Book, Chapter 2: General Institutional Responsibilities.)*

Adequate procedures are not in place at Pikes Peak Community College (PPCC) to ensure that the ECAR is kept available for review by auditors. PPCC could not provide its ECAR for Fiscal Year 2002, because it had been misplaced. PPCC is noncompliant with recordkeeping requirements regarding its ECAR, and we were unable to observe some of the most critical data elements that form the basis of the school's approval for participation in the SFA programs as shown on the ECAR.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Special Tests.)

Recommendation No. 48:

Pikes Peak Community College should establish procedures to ensure that the Eligibility Certification Approval Report is kept available for review by auditors.

Pikes Peak Community College Response:

Agree. Pikes Peak Community College agrees and will take steps to ensure the Eligibility Certification Approval Report is kept available for review in the future. Implementation date: June 2003.

Award Packaging

The U.S. Department of Education (ED) and the Colorado Commission on Higher Education (CCHE) prescribe a broad range of responsibilities that schools participating in the Title IV Student Financial Assistance programs and the state-funded student assistance programs, respectively, must meet. These responsibilities cover such areas as institutional fiscal operations and network of responsibilities; institutional eligibility; financial responsibility; administrative capability (including separation of functions); and other areas such as consumer information, institutional policies and procedures, program evaluation, return of Title IV funds, record maintenance, and disclosure of student information. The ED also requires schools to be administratively capable. (*June 2001 United States Department of Education Blue Book, Chapter 2: General Institutional Responsibilities; 6/17/02 Colorado Commission on Higher Education, Appendix A Guidelines.)*

In conducting our audit, we noted that Trinidad State Junior College (TSJC) had a small financial aid staff of two people, and awards financial aid manually to each student rather than using the available automated packaging programs that the other Colorado Community College System (CCCS) schools use. We also noted several areas highlighted in the completed CCHE Financial Aid Questionnaire that could be improved upon.

The manual awarding process does not appear efficient, given TSJC's limited financial aid staff size. In addition, the areas highlighted may make it difficult for the College to meet the required responsibilities of schools that participate in the Title IV and state-funded programs and may make it difficult to maintain optimum segregation of duties and administrative oversight. Some of the common responsibilities assigned to a financial aid office are to (1) develop written policies and procedures on the way the school administers Title IV and state-funded programs (2) adhere to the principle of separation of functions and (3) keep current on changes in laws and regulations to ensure that the school remains in compliance. Schools should also evaluate the way they administer Title IV and state-funded programs on a regular basis by evaluating and analyzing existing procedures, practices, and policies to determine where improvements are needed. This is a priority area of the ED and should also be a priority for financial aid administrators and school business officers. Some components of administrative capability include (1) administering Title IV programs according to all Title IV requirements (2) using an adequate number of qualified persons to administer Title IV programs in which the school participates (3) administering Title IV programs with adequate checks and balances in the system of internal controls (4) not demonstrating any significant problems in the ability to administer Title IV programs and (5) not appearing to lack the ability to administer Title IV programs appropriately.

In reviewing TSJC's completed CCHE Colorado Financial Aid Questionnaire, KPMG noted the following areas to improve upon:

- The school does not have a financial aid advisory committee.
- The Pell grant that a student is entitled to receive is not counted as a resource if a student has not applied for it. For need-based programs, institutions are to consider the amount of Pell funds a student is entitled to receive as a resource regardless of whether the student has applied for the Pell grant.
- The written packaging policy does not address the method by which aid is awarded to less than full-time students.
- The institution has not established due process procedures for students suspected of fraud and abuse in state-funded programs and has not established penalties for proven fraud.

The limited staff size creates an environment where segregation of duties is difficult to achieve, and the manual awarding leads to a higher likelihood of human error. These deficiencies cause a large caseload that must be manually processed by the staff, and the lack of procedures could result in erroneous amounts being awarded to students. The manual processing by so few people creates time constraints, which makes it difficult for the financial aid office to comply with some of the common responsibilities assigned to financial aid offices and makes it difficult to maintain administrative oversight independently. In addition, these conditions increase the risk of misuse of funds and other resources. A financial aid advisory committee would provide monitoring and secondary review of the overall award process and help ensure applicants are treated equitably.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Eligibility.)

Recommendation No. 49:

Trinidad State Junior College (TSJC) should consider the need to automate the award packaging process and consider the need for additional mitigating controls to ensure proper segregation of duties for carrying out the SFA programs. This would allow the common responsibilities of a financial aid office administering the Title IV and state-funded programs to be complied with in a more adequate, efficient, and timely manner. This

would reduce the potential for human error and would also ease the burden imposed on the limited staff.

TSJC should establish a financial aid advisory committee whose duties include, but are not necessarily limited to, advising the financial aid director concerning policy issues. TSJC should incorporate into its packaging policy an allowance for federal Pell grant funds a student may be entitled to receive, regardless of whether the student applied for a Pell grant. The packaging policy should also address the method by which aid is awarded to less than full-time students. Finally, TSJC should establish due process procedures for students suspected of fraud and abuse in state-funded programs and should establish penalties for proven fraud.

Trinidad State Junior College Response:

Agree. Trinidad State Junior College agrees and will implement by June 2003.

Student Financial Aid Policies and Procedures

As discussed previously, we noted a number of findings and recommendations related to certain college's student financial aid and the controls in place over compliance requirements. While we did note that student financial aid programs are carried out by each of the individual colleges in accordance with institution policies and procedures, we believe there is an opportunity to share best practices and help ensure compliance systemwide with student financial aid requirements. For example, a standard policy for calculating the return of Title IV funds would benefit the entire system and ensure consistent compliance with the requirement. A similar policy on use and documentation of professional judgments would help the colleges to ensure awards are being made to eligible students.

(CFDA Nos. 84.007, Federal Supplemental Educational Opportunity Grants; 84.033, Federal Work Study Program; 84.063, Federal Pell Grant Program; Other.)

Recommendation No. 50:

Colorado Community College System (CCCS) should evaluate the student financial aid findings noted above and ensure all colleges are in compliance and have adequate internal controls over the areas noted. CCCS should also develop systemwide policies to address

key student financial requirements such as return of Title IV funds and professional judgments.

Colorado Community College System Response:

Agree. Colorado Community College System does not currently have resources dedicated to coordinating and monitoring financial aid operations at its 13 colleges. Resources will need to be reallocated or added to fulfill this recommendation. This recommendation will be implemented by June 2003.

Vocational Education - Basic Grants to States

When entities are funded on a reimbursement basis, program costs must be paid for by entity funds before reimbursement is requested from the federal government. When funds are advanced, recipients must follow procedures to minimize the time elapsed between the transfer of funds from the U.S. Treasury and disbursement (e.g., maximum of three days prior to disbursement for expenditures for the purpose for which the funds were intended under the grant).

When advance payment procedures are used, recipients must establish similar procedures for subrecipients. Pass-through entities must monitor cash drawdowns by their subrecipients to ensure that subrecipients conform substantially to the same standards of timing and disbursement amounts that apply to the pass-through entity. Colorado Community College System (CCCS) receives Vocational Education - Basic Grants to States funds on a reimbursements basis; however, we found that CCCS makes payments to subrecipients on a quarterly basis based on internally determined percentages of 23 percent in the first quarter, 27 percent in the second quarter, and 25 percent in the third and fourth quarters. During Fiscal Year 2002, CCCS distributed $5,065,000. CCCS does not know if its subrecipients spent their allocations in accordance with these predetermined percentages prior to the distributions. We also noted that CCCS requested reimbursement from the federal government of $31,523 greater than the amount distributed.

We noted that CCCS makes quarterly payments to grantees without supporting documentation of the amount spent. CCCS periodically requests reimbursements based on expenditures reported in its general ledger. However, due to manual processing of transactions, errors were made in the reimbursement request. CCCS is not tracking the timing of reimbursements at the subrecipient level to ensure that monies are not advanced. The result of this practice is that CCCS could be advancing monies, rather than

reimbursing actual expenditures incurred. CCCS also received more federal funds than it spent.

This finding resulted in questioned costs of $31,523. CCCS applied this amount against its Fiscal Year 2003 federal draw.

(CFDA No. 84.048; Vocational Education - Basic Grants to States; Cash Management and Allowable Costs.)

Recommendation No. 51:

Colorado Community College System (CCCS) should ensure funds are disbursed to subrecipients only on an as-needed basis and only reimburse subrecipients for amounts expended on allowable costs, where the expenditures are adequately documented. CCCS should evaluate alternatives to ensure that expenditures are for allowable costs and activities before providing reimbursement.

CCCS should also ensure that entries to record revenue are accurate and complete so that requests for reimbursements are also accurate.

Colorado Community College System Response:

Agree. Colorado Community College System agrees. Additional reporting and monitoring processes will need to be initiated, potentially requiring resources not currently available in this operation. The System will seek to fulfill this recommendation in the most cost-effective manner possible and develop a plan to address these deficiencies by June 2003.

Allowable Costs and Subrecipient Monitoring

Federal regulations related to subrecipient monitoring require that grantees establish and implement procedures for the ongoing monitoring of their delegate agencies (subrecipients) carrying out Carl Perkins - Vocational Education operations. Monitoring of grantees should include controls to ensure that reimbursements to subrecipients are adequately supported as to propriety for allowability within program requirements.

Colorado Community College System (CCCS) performs annual audits of a limited number of grantees to monitor subrecipients subsequent to year-end to ensure expenditures incurred by the subrecipient were for allowable costs and activities. However, adequate

procedures are not in place during the year to document and ensure that subrecipients are administering federal awards in compliance with federal requirements as they apply to allowable costs and activities and matching requirements. CCCS also does not obtain and review subrecipient A-133 reports. Subrecipients comprise approximately 60 percent of federal expenditures totaling approximately $5,065,000 for Fiscal Year 2002.

CCCS is not able to adequately support monitoring of subrecipients for the grant funds paid and verify that funds were specifically used for authorized purposes within the program during the year.

(CFDA No. 84.048; Vocational Education - Basic Grants to States; Allowable Costs and Subrecipient Monitoring.)

Recommendation No. 52:

Colorado Community College System should strengthen monitoring procedures and the documentation over subrecipients receiving funds for the Carl Perkins - Vocational Education program, including:

a. Ensuring that subrecipients expending $300,000 or more in federal awards during the fiscal year have met the audit requirements of OMB Circular A-133 for that fiscal year.

b. Issuing management decisions on audit findings within six months after receipt of subrecipients' audit reports, and ensure that subrecipients take appropriate and timely corrective action.

c. Evaluating its other monitoring procedures to ensure compliance with applicable requirements.

Colorado Community College System Response:

Agree. Additional internal audit resources may be required to satisfy this recommendation. Additional reporting will be required of the subrecipients as well. CCCS will develop a plan to achieve the necessary audit coverage during Fiscal Year 2003.

Preparing Tomorrow's Teachers to Use Technology

The Preparing Tomorrow's Teachers to Use Technology grant is funded on a reimbursement basis. When entities are funded on a reimbursement basis, program costs must be paid for by entity funds before reimbursement is requested from the federal government. Colorado Community College System (CCCS) received reimbursement for which it had not expended monies during Fiscal Year 2002.

CCCS overdrew its Preparing Tomorrow's Teachers to Use Technology grant by $105,234 during Fiscal Year 2002. This error was the result of improper posting of a previous cash receipt and errors in recording accounts receivable. This resulted in questioned costs of $105,234. These funds were applied against the first Fiscal Year 2003 request for reimbursement.

(CFDA No. 84.342; Preparing Tomorrow's Teachers to Use Technology; Cash Management.)

Recommendation No. 53:

Colorado Community College System should strengthen controls over its cash management process to ensure requests for reimbursement are for costs incurred.

Colorado Community College Response:

Agree. CCCS will take steps necessary to strengthen cash management controls by June 2003.

Colorado School of Mines

The Colorado School of Mines was founded on February 9, 1874. The primary emphasis of the Colorado School of Mines is engineering, science education, and research. The School operates under the authority of Article 40, Title 23, C.R.S.

The following comments were prepared by the public accounting firm of BKD, LLP, who performed audit work at the Colorado School of Mines.

Receipt and Use of Federal Funds

The Colorado School of Mines (the University) participates in numerous federal grant programs throughout the year. These grants are largely for research and development programs within the University and for student financial aid. Research and development and student financial aid were tested as major programs under the Office of Management and Budget (OMB) Circular A-133 for the fiscal year ended June 30, 2002. During the year the University had expenditures under these federal grants of $14.8 million. Our testing noted instances of noncompliance with the requirements of federal grants or OMB Circular A-133 as follows.

Improve Subrecipient Monitoring

In the fiscal year ended June 30, 2002, the University reported on its Schedule of Federal Assistance funds passed through to subrecipients of $2,850,048 in eight programs.

The requirements set forth in the OMB Circular A-133 provide that pass-through entities (in this case the University) obtain reasonable assurance that federal award information and compliance requirements are identified to subrecipients, subrecipient activities are monitored, subrecipient audit findings are resolved and the impact of any subrecipient noncompliance on the pass-through entity is evaluated. Also, the pass-through entity should perform procedures to provide reasonable assurance that the subrecipient obtains required audits and takes appropriate corrective action on audit findings. During our testing of research and development grants we found that the University did not adequately document information about its subrecipient monitoring.

The University designates a principal investigator for each grant, usually a university professor. This investigator is responsible for approving all expenditures submitted by subrecipients and for supervision of the subrecipient. While proper supervision may be occurring, the University did not have documentation to support the monitoring process. Without the documentation, it is not possible to determine if all federal requirements had been met.

The University should maintain a database that lists all subrecipients. The database should document that the subrecipients have received an OMB Circular A-133 audit and are aware of the guidelines of this regulation. University personnel should then document their review of the audit and respond to an reported findings and questioned costs. If the University does not receive an A-133 audit from the subrecipient, a certification letter should be sent to the subrecipient. The subtitles on the certification letter should include the following: 1) audit not complete, 2) audit complete/no findings, 3) audit complete/related findings, or 4) not subject to audit. The database should also track any

other communication or monitoring of the subrecipient by the principal investigator. If a certification letter or A-133 audit is not received the subrecipient should be considered not in compliance. If a subrecipient is not in compliance, the principal investigator should be notified. The principal investigator should inform the subrecipients that payments will be withheld until they are in compliance with regulations.

This recommendation was made in the prior two years audit and has not been corrected.

(Various CFDA Nos.; Research and Development Cluster; Subrecipient Monitoring.)

Recommendation No. 54:

The Colorado School of Mines should develop subrecipient monitoring documentation policies and procedures to help ensure that subrecipient files are properly maintained and provide documentation for the monitoring that has occurred.

Colorado School of Mines Response:

Agree. The Colorado School of Mines continued to strengthen this area within the past twelve months. A database was created to track all subrecipients; however, the procedure to certify compliance concerning the recipient's completion of an A-133 audit has not yet been implemented. This will be implemented in the current fiscal year. Implementation date April 2003.

Proper Close-out Procedures

During the fiscal year ended June 30, 2002, the University completed approximately 100 projects for which it received federal research and development grants. To ensure compliance with applicable laws, regulations, and provisions of each grant, the University documents "close-out" procedures for each project completed. Documentation of close-out procedures includes contractual and financial status checklists and conversation logs between the department receiving the grant and the grantor. Close-out procedures are in place to ensure that additional expenses are not charged to the project after it has been completed. In our testing, 1 of the 21 closed projects tested lacked documentation of close-out procedures due to an oversight in the grant department. While we did not observe improper expenditures in this grant, there is risk to the University when the policies are not followed.

(See Appendix A, Colorado School of Mines, for listing of applicable CDFA Nos.; Special Tests and Provisions.)

Recommendation No. 55:

The Colorado School of Mines should follow the policies and procedures to help ensure close-out procedures are documented for each project completed to prevent erroneous expenses being charged to these projects and ensure compliance with applicable laws and regulations.

Colorado School of Mines Response:

Agree. There is a documented process and procedure in place to close-out each project. The audit identified an error in one phase of the close-out database. This technical error was corrected during the current fiscal year. An additional procedure was also added to identify all closed-out projects on the financial system and the close-out database. Implementation date January 2003.

Calculating Pell Grant Amounts

The University has 411 students who received approximately $955,446 in grants under the Federal Pell Grant Program. Under the Federal Pell Grant Program, amounts are awarded to students based on the students' expected family contribution, expected cost of attendance and enrollment status. The University calculates amounts to be awarded to students using the "Regular Payment Schedule for Determining Scheduled Awards" provided annually by the federal government. In our testing, 1 of the 30 students tested was awarded an incorrect amount of $125 and should have been awarded $2,900. The student's Pell Grant was calculated based on part-time rather than full-time status in school.

(CFDA No.84.063; Federal Pell Grant Program; Eligibility.)

Recommendation No. 56:

The Colorado School of Mines should develop a process for reviewing financial aid awards to ensure that Pell Grants are awarded in the correct amount.

Colorado School of Mines Response:

Agree. The Colorado School of Mines has policies and procedures in place for calculating the correct financial aid awards. The procedures will be reviewed for an opportunity to strengthen them. When the error was discovered, it was corrected and the amount was properly remitted to the student. Implementation date March 2003.

Transmissions to the National Student Loan Data System

The University has 1,724 students who received approximately $7,455,056 in loans under the Federal Family Education Loan (FFEL) program. Under the FFEL program, the University is required to communicate to lenders and guarantors changes in student status when students graduate, withdraw or drop out. The University performs the required communication through the National Student Loan Data System (NSLDS). The University transmits all required information to NSLDS which makes available the information to lenders and guarantors. The transmission to NSLDS for spring graduates did not include final grades for the spring semester. As a result, graduation dates were not included for students who graduated in May 2002. This was due to the transmission being sent to NSLDS prior to the final grades being entered into the System. The University did retransmit the information once the problem was detected. This is a violation of the provision of the FFEL program. As a result of NSLDS not receiving this information, and therefore the lenders not receiving graduation dates, students who graduated would not have gone into repayment status on their loans at the correct time. The University should determine the cause of the missing information and develop a report review system to ensure all required fields are communicated in the future.

(CFDA No.84.032; Federal Family Education Loans; Special Tests and Provisions.)

Recommendation No. 57:

The Colorado School of Mines should develop policies and procedures to help ensure that all communications with National Student Loan Data System (NSLDS) are complete, accurate, and timely.

Colorado School of Mines Response:

Agree. Colorado School of Mines is required to transmit data three times per semester to the NSLDS. NSLDS publishes requirements and due dates for submittal of information. Due to an internal process error, the transmittal cited was submitted earlier than the due date. Controls are now in place to ensure that the University does not submit the report early nor without all of the required information. Implementation date February 2003.

Student Loan Division

The Colorado Student Loan Program (CSLP or Student Loan Division or the Division) was created by an act of the Colorado Legislature in June 1979 to assist Colorado residents in meeting expenses incurred in availing themselves of higher education opportunities. CSLP's mission is to provide students with access and choice in higher education by ensuring the availability and value of financing programs.

The following comments were prepared by the public accounting firm of Clifton Gunderson LLP, who performed audit work at the Student Loan Division.

Duplicate Billings for Default Aversion Fees

The Colorado Student Loan Program (CSLP) engages in default aversion activities designed to prevent the default on a loan by a borrower. Default aversion activities are activities of a guaranty agency, such as the CSLP, that provide collection assistance to the lender on a delinquent loan, including due diligence activities, prior to the loan being legally in a default status. In general, the CSLP may transfer a default aversion fee (DAF) from its Federal Fund to its Operating Fund to be used in the operations of the Division. The fee is based on 1 percent of the total unpaid principal and accrued interest owed on the loan in cases where the lender requests default aversion assistance. The DAF should be

paid only once on each loan. During our audit procedures, we noted instances where the CSLP was billing for the DAF more than once for the same loan.

When we notified the CSLP of the problem, the CSLP investigated and found that the duplicate billing problem began with the implementation of a new automated process called Common Account Maintenance (CAM) in January 2002 to support the addition and updating of pre-claim information. This billing duplication was caused by incorrectly setting a DAF indicator required for loans to be eligible for billing in the new system beginning January 2002. The indicator pulled loans into the new billing, even though the DAF billing had already occurred on a previous pre-claim for the same loan. As a result of the duplicate billings, excess funds were transferred and used for the operations of the CSLP. The CSLP identified that total errors accumulated to $420,643. The errors were corrected and adjusted accordingly at June 30, 2002.

(CFDA No. 84.032; Federal Family Education Loans; Reporting Requirements, Special Tests.)

Recommendation No. 58:

The Colorado Student Loan Program (CSLP) should ensure that all new processes affecting the default aversion fee (DAF) billing system are adequately tested to avoid unforeseen impacts on the system and possible errors. Additionally, the CSLP should continue to implement and follow established control and system procedures to correct the duplicate billing errors within the system.

Student Loan Division Response:

Agree. The Division has developed processes to identify all duplicate DAF billings. The Division ran a one-time system correction to delete the DAF billing information for the second claims that had been erroneously billed. In addition, a CAM update process was revised so that it will identify a loan that has previously been billed for the DAF and contain the correct billing indicator. To prevent further problems with DAF billing, the CSLP has proposed the following processes to eliminate these errors.

- A process to identify potential duplicate DAF billings will be run each month prior to the running of the DAF billing process. If any records are selected for this report, DAF billing will not be run until the problems can be researched and resolved.

- A process has been developed to audit the DAF information for all active and cancelled pre-claims. This process will be run prior to running the DAF billing process. If any records are selected for this report, DAF billing will not be run until the problems can be researched and resolved.

- A process to identify duplicate DAF billings will be run after running the DAF billing process. If any records are selected for this report, they will be researched and corrected before running any additional DAF billing cycles.

These procedures were adopted by the Division in July 2002.

Default Aversion Fee Computed on Incorrect Loan Balance

In another problem related to the default aversion fee (DAF), we noted that in some instances the DAF was not calculated as it should be on the principal and interest amounts owed at the time the default claim was filed, but rather on the current principal and interest amounts at billing. Using incorrect principal and interest amounts in computing the DAF resulted in overbilling $731 in fees. Excess fees were billed because the computation was based on additional accrued interest on the loan(s). Subsequent to our test work, the Division identified that the problem began with the implementation of the new Common Account Maintenance (CAM) automated process in January 2002. When the CAM system was updated and the transactions for existing pre-claims were processed, the DAF billing amounts were updated so that they no longer reflected the original principal and interest amounts on which the DAF should have been calculated. The error in the system was corrected and the adjustment to the financial statements was made as of June 30, 2002.

(CFDA No. 84.032; Federal Family Education Loans; Reporting Requirements, Special Tests.)

Recommendation No. 59:

The Colorado Student Loan Program should develop and implement a process and procedures to ensure that the default aversion fees (DAF) are computed on the correct base amounts. Additionally, the CSLP should develop procedures to identify problems and prevent errors before they occur.

Student Loan Division Response:

Agree. The Division has developed processes to identify all incorrect DAF billings. Procedures were developed to identify all claims where the current DAF principal and interest amounts were not equal to the DAF amounts when the claim was initiated. A one-time fix was also run to correct the DAF principal and interest amounts within the system, and the Division verified that all corrections to the system were performed correctly. In addition, the procedures have been changed so that when a claim is added to the system, the CAM process will initially set the DAF principal and interest. However, when subsequent transactions are received for the same claim, the transactions will not update the DAF principal and interest amounts. These procedures were adopted by the Division in July 2002.

Accrued Interest on Defaulted Loans Not Computed Correctly

The Colorado Student Loan Program (CSLP) files a claim with the U.S. Department of Education (DE) for reinsurance for defaulted loans after a lender files a claim for payment on the defaulted loan with the CSLP. The CSLP will continue to collect from the borrower. A certain amount of subsequent collections received from the borrower on defaulted loans is retained by the CSLP. The collections from the borrower are split between principal and interest. As interest rates change, the new rate is entered into the system via a table. When the interest rate for a variable rate claim changes, an interest calculation (IC) transaction is created to accrue the interest to the effective date of the new interest rate. IC transactions are used to ensure the accuracy of interest accruals and provide a trail for changes to interest rates for specific claims. After the IC transaction occurs, the claim is updated with the new rate.

Through a process where the CSLP assigned an interest indicator to each claim, the CSLP identified instances where certain claims dating back to 1994 had missing IC transactions. Due to the missing IC transactions, payments received subsequent to the IC transactions were not applied using the correct interest rates. The CSLP identified that the IC transactions were not correctly applied primarily due to errors in the computer system.

The CSLP identified the estimated amount of underaccrued interest on affected claims was approximately $39,082, which resulted in the CSLP's collecting less than what was actually due from the borrowers. The CSLP has decided to absorb the cost of the underaccrual error. In addition, the CSLP identified that it had estimated a total of

$13,008 in overaccrued interest. This resulted in the CSLP's collecting more than what was actually due from the borrowers. The CSLP is required by its policy to repay amounts to borrowers that are overcollected in excess of $20. The aggregate amount that the CSLP will refund to borrowers over this limit is $4,858. The under- and overaccrued interest amounts are not reflected as of June 30, 2002.

(CFDA No. 84.032; Federal Family Education Loans; Reporting Requirements, Special Tests.)

Recommendation No. 60:

The Colorado Student Loan Program should refund the appropriate amounts to the borrowers who were charged excess interest. The CSLP should develop procedures to prevent future interest calculation (IC) transaction errors and to identify and correct inaccurate IC transactions within the computer system so that the proper interest accruals are made to the appropriate claims.

Student Loan Division Response:

Agree. The Division believes it has identified the extent of the problem with the missing IC transactions. The CSLP has corrected all interest rates through July 1, 2002. The CSLP has decided to absorb the cost of the underaccrual error. Since CSLP has corrected the interest rates as of July 1, 2002, for all of the affected claims with underaccrual errors, the interest will be accruing correctly from July 1, 2002, forward on the reduced loan balances. The CSLP will make a one-time correction to those accounts where the proper IC transaction was not applied and resulted in overaccrued interest; plus, the CSLP will refund overaccruals in excess of $20. The Division will implement changes that need to be made to the ongoing system to prevent these errors from occurring in the future. This includes changes to procedures to ensure that interest rate tables are updated correctly prior to the start of a new fiscal year, changes in the interest rate audit process, and the weekly generation of a missing IC audit report for further analysis.

In addition, an internal change-control process involving multiple departments in the agency responsible for ensuring entry of correct interest rate changes in the future has been established. These procedures were adopted by the Division in September 2002.

Department of Human Services

Introduction

The Department of Human Services is responsible, by statute, for managing, administering, overseeing, and delivering human services in the State. While many of these services are provided through county departments of social services, the Department is also responsible for the direct operation of a number of facilities that provide direct services, including mental health institutes, nursing homes, and youth corrections. Please refer to page 37 in the Financial Statement Findings section for additional background information.

Compliance With the Cash Management Improvement Act

In Fiscal Year 2002 the Department of Human Services (DHS) expended $753 million for the administration of 75 federal programs, including programs at four of the State's nursing homes. The Department operates on a reimbursement basis with the federal government, fronting general fund dollars for federal programs prior to requesting federal reimbursement for the appropriate share. This reimbursement process is governed by the federal Cash Management Improvement Act (CMIA). The purpose of CMIA is to minimize the time between when a state makes an expenditure and when the federal reimbursement is received so neither party incurs a loss of interest on the funds. In other words, the intent is that the payment issued by the Department should clear the State's bank on the same day the federal reimbursement is received for the related expenditure.

According to CMIA, the State must enter into a formal agreement with the federal Treasury Department to establish reimbursement schedules for selected federal programs awarded to the State. Under Colorado's agreement, 13 of the Department's programs were covered under CMIA for Fiscal Year 2002. Per the agreement, the Department should draw down federal funds three business days after expenditures are incurred or payments are mailed, depending on the method of payment (electronic funds transfer or warrants, respectively). In practice, this means that the Department should request reimbursement for a qualifying expenditure the third day after an electronic funds transfer (EFT) transaction is approved on COFRS or four days after a payment voucher for a warrant is approved on COFRS. The 13 programs covered under CMIA accounted for approximately $624 million, or 83 percent of the Department's total federal expenditures in Fiscal Year 2002.

During our prior years' audits, we have identified ongoing problems with the Department's cash management related to federal programs. Specifically, in Fiscal Year 2001 we found problems with the Department's draw patterns for all of its 14 programs covered under the CMIA Agreement. For example, we found that the Department's receivable balances for each of these programs represented as much as five months of expenditures outstanding. During our Fiscal Year 2002 audit, we found that the Department made a concerted effort during the year to address its cash management problems, including improving its monitoring and oversight of federal drawdowns. The Department implemented a detailed tracking system showing the transactions automatically generated by COFRS, which aided the Department in becoming aware of timeliness issues related to federal drawdowns and enabled it to investigate problems sooner. While the results of our testwork discussed below indicate that the Department has made substantial improvements in cash management, they indicate the Department should further ensure that all draws for EFT payments are made timely and in accordance with the CMIA agreement.

Results of Draw Pattern Testing

In order to determine if the Department followed the draw pattern contained in the formal agreement during Fiscal Year 2002, we tested a sample of 87 warrant and electronic funds transfers for CMIA-covered federal grants. Specifically, we determined the number of days between when the federal expenditure was incurred or when the warrant was mailed, depending on the type of payment, and when federal reimbursement was requested, or the "draw pattern." The results of our testwork are contained in the following table.

Colorado Department of Human Services
Cash Management Patterns
Fiscal Year 2002

Draw Pattern in Days

Electronic Funds Transfer[1]	Sample Transactions			Warrants[2]	Sample Transactions		
	Number	%	Dollars		Number	%	Dollars
0-1 days	0	0%	$0	0-1 days	0	0%	$0
2 days	0	0%	$0	2 days	35	66%	$959,000
3 days (required under CMIA agreement)	12	35%	$1,438,000	3 days (required under CMIA agreement)	13	24%	$41,000
4 days	20	59%	$110,000	4 days	3	6%	$49,000
8 days	2	6%	$14,000	5 days	2	4%	$18,000
TOTAL	34			TOTAL	53		

Source: Office of the State Auditor analysis of Department and COFRS data.
[1] Per the State's agreement with the federal Treasury Department, the Department should request reimbursement of federal funds three days after payments are made through Electronic Funds Transfers (EFTs).
[2] Per the State's agreement with the federal Treasury Department and our discussions with Department and COFRS staff regarding the timeframe required for warrant payments, the Department should request federal funds reimbursement three days after warrant payments are mailed.

For EFT payments, our testwork indicates that in some instances the Department is fronting state general funds longer than required by the draw schedule contained in the formal CMIA agreement. In 65 percent of the items tested, federal draws were requested within four or eight days rather than three days as required. From the perspective of the federal government, this is not an issue because federal funds are not being requested sooner than specified in the CMIA agreement. Rather, the delay means that the State is about one to five days behind in requesting federal funds and thus loses interest on those funds for that period.

On the other hand, for warrant payments, the Department requested federal reimbursement one day earlier than allowed by the draw schedule for 66 percent of the transactions tested. This means that the State could be required to pay interest to the federal government on the early payments.

According to the terms of the CMIA agreement and guidance the Department has received from the Office of the State Treasurer, the Department should draw federal funds three days after EFT payments are approved on COFRS and four days after warrants are approved on COFRS. However, Department staff indicate that they currently use the three-day draw

schedule for both types of payments. Thus, the Department should revise its existing federal draw procedures for warrant payments to ensure draws are made in compliance with the CMIA agreement. Further, the Department should continue to improve its draw patterns for EFT payments to lessen the potential loss of interest to the State.

(CFDA Nos. 10.551, 10.555, 10.561, 84.126, 93.558, 93.563, 93.568, 93.575, 93.596, 93.658, 93.667, 93.959, 96.001; Food Stamps, National School Lunch Program, State Administrative Matching Grants for Food Stamp Program, Rehabilitation Services - Vocational Rehabilitation Grants to States, Temporary Assistance for Needy Families, Child Support Enforcement, Low-Income Home Energy Assistance, Child Care and Development Block Grant, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Foster Care - Title IV-E, Social Services Block Grant, Block Grants for Prevention and Treatment of Substance Abuse, Social Security - Disability Insurance; Cash Management)

Recommendation No. 61:

The Department of Human Services should continue to improve its cash management for federal programs by ensuring federal draws are made timely and in accordance with the CMIA agreement. This should include revising its federal draw procedures for warrant payments to reflect the requirements of the CMIA agreement.

Department of Human Services Response:

Agree. The Department of Human Services will continue to work toward processing federal drawdowns so that the cash is received from the federal treasury on the same day as the cash leaves the State's bank account for federal expenditures. This will be done by meeting with the Division of Information Technology to ensure that all parties understand the relationship and timing of document processing from the time a request for payment is entered into the State's accounting system through the date a warrant is sent out or a request is sent to the bank to transfer payment electronically. The Department will also meet with the appropriate personnel at the Office of the State Treasurer to gain an understanding of when the cash is received by the State's bank in relation to when the federal drawdown request is made. The Department's drawdown procedures will be modified accordingly and staff will be trained. We will also work with the Office of the State Treasurer to clarify wording in the federal/state agreement to reflect the flow of documents and cash.

Implementation Date: March 31, 2003.

TANF Program Payment Voucher Review Process

In 1996, Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) established federal welfare reform requirements and created the Temporary Assistance for Needy Families (TANF) program. In July 1997 the Department of Human Services implemented TANF in Colorado as the "Colorado Works" program.

The Department purchases goods and services as part of its administration of the program. These purchases include office supplies, contracted employees, training sessions, and other expenditures necessary for the operation of the TANF program. During our Fiscal Year 2002 testing of 49 federal grant program transactions, we reviewed purchases of goods and services made by TANF program staff. Out of the seven transactions tested, three contained errors. Specifically, we found the following:

- One payment was coded incorrectly on COFRS. Department staff incorrectly coded a $3,800 payment for services rendered by a contractual employee to an expenditure code for registration fees. Further testwork indicated that an additional eight payments totaling about $47,300 made to the contractor for the same type of service during the year were also coded incorrectly.

- One payment was made for services rendered 8 to 11 months earlier. Due in part to program staff turnover and in part to problems with a vendor's invoice, services rendered in January, March, and April 2001 totaling $2,058 were not paid until December 2001. Further, a payable was not established for these services in Fiscal Year 2001 when they were provided as required by State Fiscal Rules. Thus, the services were charged against the wrong fiscal year's budget.

- One payment amount did not agree to supporting documentation. Supporting documentation provided for one payment was $13.50 less than the payment amount. While this amount is small, it raises concerns regarding the review process over TANF payments, since the amount paid was greater than the amount due.

Staff indicate that TANF purchases are reviewed for reasonableness and accuracy by both program and accounting staff prior to purchase and payment approval. However, the errors identified in our sample indicate that the review process needs to be strengthened to ensure that payment vouchers are mathematically accurate, payments are made timely and charged to the correct fiscal year, and expenditures are coded to the proper accounts.

(CFDA No. 93.558, Temporary Assistance for Needy Families; Activities Allowed or Unallowed, Allowable Costs/Cost Principals.)

Recommendation No. 62:

The Department of Human Services should strengthen the payment review process within the TANF program to ensure expenditures are consistent with supporting documentation, paid timely and charged to the correct fiscal year, and coded to the proper account.

Department of Human Services Response:

Agree. Training of the program accountant who reviews the TANF encumbrance and expenditure coding took place January 7, 2003. The coding will be reviewed in the future for all purchase orders and payment vouchers. If changes are made on the invoice amounts, an adding machine tape will be included with the payment voucher to prove the new total. The logging of invoices in vouchering will be monitored more closely. The training for the vouchering unit will be complete by January 31, 2003.

Implementation Date: January 31, 2003.

Foster Care Quality Assurance Process

In Fiscal Year 2002 the Department expended $47.8 million in state and federal funds for the administration of the Title IV-E Foster Care program. The purpose of the program is to provide safe, appropriate, 24-hour, substitute care for children temporarily removed from their home. The Foster Care program is overseen by the Department's Office of Child Welfare and administered locally by the county departments of social services.

Federal law requires states to conduct quality assurance reviews of all children placed in foster care on a periodic basis to ensure the safety and well-being of children within the Foster Care system. We found during our audit that while the Department conducted quality assurance reviews of all children in out-of-home Foster Care settings during Fiscal Year 2002, Department staff did not conduct quality assurance reviews of children receiving "in-home" services or placed in out-of-home settings for fewer than six months.

According to Department policies, quality assurance reviews are performed by the Foster Care Administrative Review Division (ARD). The purposes of the reviews are to evaluate the adequacy and quality of services provided by the county, evaluate measures implemented to address identified problems, and identify strengths and weaknesses of each county's Foster Care program. Department staff perform this function through review of children's case files. Reviews are performed for those children in out-of-home settings for longer than six months in conjunction with state- and federally required face-to-face administrative reviews.

In prior years, ARD staff selected for review a random, stratified sample from those children placed in "in-home" and short-term out-of-home settings. Specifically, staff would select and review case files for a sample of foster care children once every six months within each of the State's 15 largest counties and once a year for all other counties. Through these reviews, the Department would assess the county's assessment, intake, and in-home service delivery system. Data collected through the case file review was reported on county and statewide aggregate reports and distributed to the counties. As of the end of our audit, the Department reported that approximately 9,400 of the 21,000 children receiving Foster Care services were considered to be in-home or short-term out-of-home placements.

Department staff indicate they were unable to select a statistically valid sample of children for review in Fiscal Year 2002 due to problems with the newly implemented statewide child welfare information system, Trails. Problems ranged from missing information due to coding problems to duplicate data. These problems are consistent with those identified in our OSA audit, *Colorado Trails System Performance Audit*, Report No. 1456, dated November 2002.

Department staff indicate that coding and duplicate data errors have been corrected and the Division will be reinstituting its quality assurance review for children in in-home and short-term out-of-home settings in January 2003. In order for the Department to ensure that it is adhering to federal regulations and that children receiving in-home and out-of-home Foster Care services are protected, it must reinstitute and maintain such a review.

(CFDA No. 93.658, Foster Care: Title IV-E; Subrecipient Monitoring.)

Recommendation No. 63:

The Department of Human Services should reinstitute and maintain a quality assurance review process over those children receiving in-home and short-term out-of-home Foster Care services.

Department of Human Services Response:

Agree. As noted in the narrative, the Quality Assurance Review Process has been reinstituted. All children, including a random sample of those receiving in-home and short-term placement services, will be reviewed. The preliminary sample of cases has been pulled from the Trails database. Per previously established procedure, the notification of cases to be pulled for the review must be provided to the county three weeks prior to the on-site review. This has been done, and the first review is scheduled for February 10, 11, 12, and 14, 2003, in Arapahoe County.

Implementation Date: January 1, 2003.

Foster Care Program Overview

As discussed previously, Colorado's foster care program provides temporary and long-term care for children who are placed outside of their homes for protection or who are in conflict with their families or communities. Federal, state, and local governments are involved in foster care in Colorado. Specifically:

- **The Colorado Department of Human Services** is responsible for overseeing foster care in Colorado. As such, it promulgates regulations, provides training, licenses child placement agencies, provides technical assistance to counties, monitors outcomes, and prepares statewide reports.

- **The 64 Colorado counties** are responsible for the day-to-day administration of foster care. When a child is initially removed from his or her home, the courts often give temporary custody of the child to the department of human/social services located in the county where the child resides. The county department is responsible for finding and placing the child in the most appropriate and least restrictive setting, which is often a family foster home. County departments can place children in foster homes certified by the county or by private child placement

agencies (CPAs). Child placement agencies recruit and certify their own foster families.

- **The Administration for Children and Families in the U.S. Department of Health and Human Services** establishes regulations for foster care through Titles IV-B and IV-E of the federal Social Security Act and through the federal Adoption and Safe Families Act. Federal funding for foster care is provided through Titles IV-E and IV-B and the Title XX Social Services Block Grant.

Most children in foster care are eligible for funding under the state/county program and Medicaid. However, specific eligibility criteria exist for the federal Title IV-E program. To be eligible for the Title IV-E program, a child must meet both of the following conditions:

- The child must be placed in foster care either by a court order or through a voluntary placement agreement. For court-ordered placements, there must be judicial determinations that "removal from the home is in the child's best interests" and that "reasonable efforts to prevent the child's removal from the home have been made." For voluntary placements, there must be a judicial determination within 180 days of the child's placement in foster care that "continuation in out-of-home placement is in the child's best interest."

- The child must be determined eligible for Aid to Families with Dependent Children (AFDC) in accordance with the July 16, 1996, regulations.

The State is not eligible for Title IV-E reimbursements for foster care maintenance payments for children placed with for-profit child placement agencies. In Calendar Year 2000 more than 50 percent of the children served in foster care were eligible for the Title IV-E program.

During Fiscal Year 2002 the Office of the State Auditor conducted a performance audit of the Foster Care Program. The audit comments below were contained in the *Foster Care Program, Department of Human Services, Performance Audit,* Report No. 1420, dated June 2002.

Oversight of Medicaid Payments to CPAs

Child placement agencies may receive additional revenue from Mental Health Assessment and Services Agencies (MHASAs) for case management services provided for foster care children receiving mental health therapies. Medicaid funds are used to pay for these services. According to the request for proposal (RFP) issued by the Department, case

management services are those "activities that are community-based and are delivered in the consumer's environment, including service planning, outreach, referral, supportive interventions, crisis management, linkage, service coordination and continuity of care, monitoring/follow-up, and advocacy." The Department is responsible for overseeing the activities of the MHASAs, which include ensuring that MHASAs are properly monitoring their subcontractors.

One CPA received nearly $29,000 in Medicaid revenue from a MHASA for case management services allegedly provided for foster children in this CPA's care in Calendar Year 2001. To receive Medicaid funds from MHASAs, a CPA submits journals to the counties participating in the CPA Medicaid Transfer Program that detail the dates and time spent managing a child's therapeutic needs. Counties are responsible for ensuring that the children listed on these journals were under the care of the CPA during the time of the claim. Counties then forward the documentation to the MHASA overseeing mental health services in the area. In 2001 the MHASA paid this CPA $60 per month for every journal that was submitted for the children placed by counties located within the MHASA's service region.

We question whether the CPA should have received Medicaid funds for case management services. We selected a sample of Medicaid payments made by the MHASA to the CPA in 2001 and 2002, and we found no documentation that this CPA's staff actually provided therapeutic case management services to foster children under its care. Staff from the MHASA and the Department of Human Services indicated that the CPAs should be documenting in a log or case file the types of case management services provided for each child. However, our review of a sample of case files and notes found no such documentation. In fact, for some of the cases where the CPA received Medicaid funds for case management services, the case notes stated that the child was not receiving therapy services.

Additionally, a representative from the MHASA stated that the manner in which the journals were filled out by the CPA raises suspicions as to the validity of the journals. Each of the journals we reviewed included one single entry for case management services provided for between one and three hours. According to the MHASA, such journals, if accurately completed, would most likely include multiple daily entries in which case management services were being provided. Furthermore, the owner of the CPA stated to us that her agency does not provide psychological case management services to children in its care and that many of the children placed through the agency do not receive therapies.

As part of the audit, we found that counties and MHASAs do not always review the journals submitted by CPAs to ensure that CPAs are actually providing case management services. Further, some of the contracts between CPAs and MHASAs do not specifically

define case management services. The Department needs to strengthen its oversight of Medicaid payments made to CPAs for case management services. It needs to ensure services are provided before payments are made.

(CFDA No. 93.777, 93.778 Medicaid Cluster; Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Subrecipient Monitoring.)

Recommendation No. 64:

The Department of Human Services should work to achieve a greater degree of accountability of Medicaid-reimbursable case management services provided by child placement agencies. To accomplish this, the Department should:

a. Ensure that MHASAs are adequately monitoring case management services provided by child placement agencies on an annual basis.

b. Ensure that MHASA contracts with child placement agencies clearly communicate the types of case management services that are reimbursable and the types of documentation that should be maintained to support that these services were actually provided.

Department of Human Services Response:

Agree. Implementation: June 30, 2003. The Department will provide written notice to all MHASAs of the following:

a. MHASAs should monitor case management services provided to MHASA clients by child placement agencies to ensure that case management services billed to the MHASAs have been provided and documented. Monitoring should be conducted at least annually; and

b. MHASA contracts with child placement agencies should address the types of case management services that are reimbursable and the types of documentation that should be maintained to support that these services were actually provided.

Written notification will be completed by July 31, 2002. The Department will review the MHASAs' contracts with child placement agencies and the MHASAs' efforts to oversee child placement agency case management services by June 30, 2003.

Financial Activities of Child Placement Agencies

County departments of human/social services often contract with child placement agencies (CPAs) to provide foster care services. These private agencies license, train, monitor, and directly compensate foster parents that they certify. Additionally, some agencies provide therapeutic services to children in their care. When a county contracts with a CPA for the placement of a foster child, the county must reimburse the CPA by the 15th of the following month for services purchased by the county. Counties pay CPAs on a monthly basis for each placement. A daily rate is determined by the county to cover the care of the child, the case management requirements, and administrative costs of the CPA. Counties may place children with any of the licensed CPAs in the State. Therefore, one CPA may be responsible for children from all over the State.

In Calendar Year 2001 counties paid 61 CPAs in the State for providing foster care services for all or a portion of the year. These CPAs were responsible for overseeing more than 5,000 foster children and were paid a total of $41 million of the $52 million (79 percent) paid by counties to CPAs and county-certified providers for family foster care services. It should be noted that payments to county-certified providers do not include group home care. CPAs may be designated as either for-profit or nonprofit entities. In Calendar Year 2001 there were 13 for-profit and 48 nonprofit CPAs licensed in Colorado. For-profit CPAs were paid nearly $10 million in this year; the nonprofits were paid more than $30 million. The State receives federal reimbursement only for children placed with nonprofit CPAs.

We selected a sample of 10 CPAs to review their financial activities. These CPAs were selected on a risk basis because of either known problems (follow-up type reviews) or because of a high-risk assessment score assigned by the Department. Depending on our initial assessment, we conducted either a comprehensive financial review or a limited review of the financial activities. We note that the results of our reviews may not be representative of all CPAs in the State.

Calendar Year 2001 revenue for the 10 CPAs in our sample ranged from about $218,000 to more than $4.3 million. These 10 CPAs were paid a total of more than $14 million, or 34 percent of the total amount paid to all CPAs in the year. These agencies were responsible for overseeing 857 children, on average, ranging between 20 and 260 children each month. Further, these agencies placed children with an average of between 5 and 101 certified foster care providers each month.

Cost Requirements

The contracts signed between counties and CPAs require CPAs to:

> Conform with and abide by all rules and regulations of the Colorado Department of Social Services, the State of Colorado and any federal laws and regulations, as such, which may be amended from time to time, and shall be binding on the Contractor and control any disputes in this Agreement.

These contracts also state that CPAs must "maintain service program records, fiscal records, documentation and other records which will sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance" of the agreement. Further, contracts signed between six CPAs in our sample and El Paso County require the CPAs to "strictly observe and conform with all applicable federal, state, and local laws, rules, regulations and orders . . . , including but not limited to . . . Office of Management and Budget Circulars (OMB)," including OMB Circular A-122.

Federal regulations require that subrecipients (i.e., CPAs) of federal funding through the Title IV-E, Title XX, and Medicaid programs must follow applicable cost principles. Specifically, Title 45 Subpart 74.27 of the Code of Federal Regulations requires that "the allowability of costs incurred by nonprofit organizations . . . is determined in accordance with the provisions of OMB Circular A-122," while, "the allowability of costs incurred by commercial organizations . . . is determined in accordance with the provisions of the Federal Acquisition Regulations (FAR) at 48 CFR part 31." One of the CPAs in our sample was a sole proprietorship. We did not identify any language that would exempt a sole proprietorship from complying with federal cost principles.

Using these cost principles, we reviewed expenditures of public foster care funds by CPAs in our sample. As we will discuss in this chapter, we identified more than $1.1 million in questionable expenditures incurred by 6 of the 10 CPAs included in our financial reviews. Questionable expenditures for each CPA ranged from about $50,000 to more than $420,000. It should be noted that the payments made to CPAs include a mixture of federal, state, and local funding sources. It was not possible to correlate specific questioned costs with the funding source. Therefore, when reporting questioned costs, we did not attempt to allocate those costs among the entities that provide the funding.

Throughout our audit, we have worked with the Department of Human Services and the Office of the Attorney General to determine the appropriate legal and administrative course of action regarding questioned costs.

Related Party Transactions

We found that four CPAs (three nonprofits and one for-profit) in our sample paid for mortgages and leases for 14 properties that were owned by these CPAs' directors, owners, or founders or their immediate family. According to OMB Circular A-122, which governs nonprofit agencies' financial activities, these transactions are referred to as "less-than-arms-length leases." Specifically, OMB Circular A-122, Attachment B, part 46(c), defines a less-than-arms-length lease as:

> One under which one party to the lease agreement is able to control or substantially influence the actions of the other. Such leases include, but are not limited to those between (1) divisions of an organization; (2) organizations under common control through common officers, directors, or members; and (3) an organization and a director, trustee, officer, or key employee of the organization or his immediate family either directly or through corporations, trusts, or similar arrangements in which they hold a controlling interest.

Further, OMB Circular A-122, Attachment B, part 46(c) states that "rental costs under less-than-arms-length leases are allowable only up to the amount that would be allowed had title to the property been vested in the organization." This provision makes allowable only those costs that would be allowed had a nonprofit organization owned the property. In other words, only the depreciable amount of the building can be considered as an allowable expenditure. Additionally, OMB Circular A-122 states that "rental costs are allowable to the extent that the rates are reasonable in light of such factors as: (1) rental costs of comparable property, if any; (2) market conditions in the area; (3) alternatives available; and (4) the type, life expectancy, condition, and value of the property leased.

Title 48 Subpart 31.205-36(b)(3) of the Code of Federal Regulations, which governs the financial activities of for-profit organizations contracting with the government, states that rental costs are allowable between "organizations under common control, to the extent that they do not exceed the normal costs of ownership, such as depreciation, taxes, insurance, facilities capital cost of money, and maintenance." Further, Title 48 Subpart 31.205-36(b)(1) states that rental costs are allowable "to the extent that the rates are reasonable at the time of the lease decision, after consideration of . . . rental costs of comparable property, (and) market conditions in the area."

As part of the audit, we reviewed mortgage and lease payments made by CPAs in Calendar Year 2001 and the public records related to these property transactions. We found that four CPAs in our sample paid more than $450,000 for properties that were owned by the directors, owners, or founders or their immediate family. Of this amount, we questioned more than $355,000 of these payments. Specifically, these property transactions included the following:

- One nonprofit CPA paid its founders about $157,000 in lease payments for a property used as the CPA's office space in Calendar Year 2001. As noted above, only the annual depreciation of about $14,000 on the building can be considered an allowable cost. As a result, the unallowable payments in Calendar Year 2001 total about $143,000.

- A for-profit CPA paid about $136,000 for mortgages or rents on seven properties owned by the agency's owner and/or the owner's immediate family in Calendar Year 2001. For five of these properties, the owner or her immediate family secured five-year mortgages. We questioned the allowability of all or a portion of the payments made by this CPA, which totaled more than $101,000. In Calendar Year 2001 one property was used as the CPA's office space. Three properties were used as foster homes and were owned by two of the owner's sons and her daughter. Another property was a former group home operated by the CPA's owner and was vacant in Calendar Year 2001. A sixth property was owned by one of the owner's sons and rented by another son, who reportedly provided respite care services in Calendar Year 2001. The CPA paid the mortgage payments to a nonrelated lender as compensation for the respite care services provided by the son renting this property. The seventh property was owned by the CPA's owner and occupied by the agency's housekeeper. According to the CPA's owner, payments for this property were made as part of the compensation package for the housekeeper for maid services provided at the office and one of the foster homes.

- Another nonprofit CPA in our sample leased five properties from one or both of its directors in Calendar Year 2001. This CPA paid $111,500 for these properties to its directors. We questioned the allowability of all or a portion of the payments made by this CPA, which totaled more than $71,000. These property transactions were less-than-arms-length leases, and payments for these properties exceeded the depreciable amount allowed and/or the market value rental costs in the area (OMB A-122, Attachment B, Paragraph 46). These properties were used as office space, foster homes, and a group care center.

- The fourth CPA paid $48,000 in lease payments to its director in Calendar Year 2001 for the agency's office space. Since only the depreciable amount on the

building in a less-than-arms-length lease is allowable, we questioned nearly $42,000 in lease payments for the property.

Additionally, we questioned nearly $20,000 in utility payments made by a CPA for a number of properties, many of which were owned by family members. Supporting documentation related to these utility payments was incomplete and it was often difficult to determine if payments were for legitimate business purposes.

Payments for Management Fees to Related Corporations

We questioned management fee payments made by one of the nonprofit CPAs in our sample to a related for-profit corporation in Fiscal Year 2001 due to the lack of documentation supporting that these costs were related to the provision of foster care. According to a draft of the independent auditor's report for the year ended June 30, 2001, this CPA paid nearly $370,000 to its related for-profit corporation in Fiscal Year 2001. The $370,000 in management fee payments appears to be excessive given that it represents more than 16 percent of the $2.2 million of this CPA's foster care revenue and no documentation of the work performed or services provided was available.

We obtained a copy of the management contract established between this CPA and its related for-profit corporation from the Division of Child Care. This contract states that the CPA will pay a management fee to its related for-profit corporation based upon the following:

- There shall first be determined the gross revenue for the month in question for the CPA.

- There shall then be subtracted from the gross revenue all amounts paid for (1) the account of employees, subcontractors, suppliers, and similar parties of the CPA; (2) all amounts paid for operating costs, including, but not limited to, rent, office supplies, telephone expenses, and similar items of the CPA; and (3) the sum of $1,000.

- The remainder of the gross revenue shall then be the monthly fee paid to the for-profit corporation.

In addition to the monthly management fee, the contract states that the CPA will pay the for-profit corporation an annual bonus. This bonus is based upon the net income of the CPA before taxes and deduction of depreciation or amortization expenses minus a

subtracted sum of $12,000. With this arrangement, it appears that all of the "profits" of the "nonprofit CPA" are being transferred to the related for-profit corporation. The method used to pay the monthly management fee and the annual bonus is not based on the services provided by the for-profit corporation, but rather on the "profits." OMB Circular A-122 Subparagraph 7(d)(1) states that when evaluating compensation to members of nonprofit organizations, trustees, directors, associates, officers, or the immediate families, "determination should be made that such compensation is reasonable for the actual personal services rendered rather than a distribution of earnings in excess of costs."

Payments to Family Members

We identified more than $108,000 in cash payments made by a for-profit CPA to the owner's family members in Calendar Year 2001. We questioned the allowability of nearly $85,000 of these payments primarily due to a lack of documentation and failure to meet the reasonableness criteria in Title 48 Subpart 31.201-3, which states that the determination of reasonable costs depends on "whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance." Specifically:

- We questioned more than $55,000 in payments made to four family members for reported respite care services. The total cash payments made to each of these family members ranged from about $8,800 to $23,300 in Calendar Year 2001. The CPA did not provide us with original documentation detailing the total hours of respite care services provided, the dates of service, the names of the children, the location where respite care was provided, or the rate of pay for the services. We questioned these costs based upon sections from Title 48 Subpart 31 of the Code of Federal Regulations and state statutes. Section 26-4-603(19), C.R.S., defines respite care as:

  > Services of a short-term nature provided to a client, in the home or in a facility approved by the state department, in order to **temporarily relieve** the family or other home providers from the care and maintenance of such client. (Emphasis added.)

  The Department noted that respite care payments typically amount to about $20 monthly per child. However, we found that respite care payments made by this CPA to the owner's family members significantly exceeded this monthly rate. For instance, payments to the owner's daughter often ranged between $1,500 and $2,100 per month and were sometimes higher than the amount the certified foster

care provider received. Department staff indicated that such large payments for respite care services would be highly unusual.

- We questioned about $30,000 in other payments by the CPA to family members in Calendar Year 2001. Nearly $26,000 of these payments were made to the owner's spouse and son for reported loan repayments. The payments were questioned due to a lack of supporting documentation that the loans were in fact made to the CPA. Additionally, we questioned more than $4,000 in payments to family members primarily due to a lack of supporting documentation showing that these payments related to the business operations.

Additionally, we questioned $55,000 that was paid by another CPA to its related for-profit corporation. These funds were used by the related for-profit corporation to pay a dividend to a shareholder. The shareholder is a related party (i.e., mother of the CPA president). It should be noted that this figure was included in the $370,000 in questioned costs for management fees discussed earlier.

Payments for Personal Purchases

We identified nearly $65,000 in credit card payments made by a for-profit CPA that appeared to be for personal use. We questioned the allowability of these payments primarily because of a lack of documentation to support that the purchases were business-related. Itemized receipts were not provided for most of the credit card purchases, which included vacation, food, clothing, beauty, and home improvement items.

Additionally, we identified nearly $9,000 in ATM cash withdrawals from the CPA's bank account that do not appear to be business-related. These ATM transactions were withdrawn from automated machines located in casinos in Cripple Creek and Black Hawk. Further, we questioned the allowability of more than $37,000 in payments made by this CPA for other types of expenditures, such as insurance on properties not used as office space paid for by the CPA, plumbing repair, and food items. We also questioned more than $23,000 in costs incurred by one CPA for vehicle payments, insurance, repairs, and gasoline costs. No business-use logs were maintained by this CPA for the costs, and as a result, we could not determine if these costs were business-related.

In the case of two other CPAs, we found that about $4,600 in payments were made to various restaurants and for an advertisement to sell a director's car. No documentation was provided substantiating the business nature of the food expenditures. OMB Circular A-122 states that "costs of amusement, diversion, social activities, ceremonials, and costs

relating thereto, such as meals, lodging, rentals, transportation, and gratuities are unallowable."

Payments to Foster Care Providers

According to department regulations, foster care maintenance payments are intended to cover the "cost of providing food, clothing, shelter, daily supervision, school supplies, and reasonable travel to the child's home for visitation." Further, department regulations, the federal Social Security Act, and the Internal Revenue Code provide definitions of who qualifies to receive foster care maintenance payments. These definitions include:

- **Department regulations:** A child maintenance payment is required to be paid to all provider types where the child is in residence.

- **Federal Social Security Act:** Foster care maintenance payments may be made on behalf of a child in the foster family home of an individual.

- **Internal Revenue Code:** Any payment made pursuant to a foster care program and paid to the foster care provider for caring for a qualified foster individual in the foster care provider's home.

In Calendar Year 2001 one CPA paid more than $150,000 in foster care maintenance payments to a foster care provider. According to the owner of this CPA and the foster care provider, these payments were made for children under this provider's care as well as for children in the care of two other certified foster care providers. This provider owned two homes where the other two providers resided during the year. According to the owner of the CPA, this provider requested that payments for all three homes be paid to him directly. This provider stated that he considers the other two providers to be his employees and he pays their housing costs as well as a wage for caring for the children in their homes.

According to internal documentation maintained by this CPA, about $83,000 in payments to this provider were intended for children in the care of the other two providers. Department documentation further indicates that payments were made to the CPA for children in the care of these two other providers. We requested documentation substantiating that the provider receiving the maintenance payments was actually passing on monies to the two other providers. However, no documentation was provided. As a result, we concluded that the $83,000 in payments paid to the one provider should have been paid directly to the other two providers.

On the basis of the definitions of foster care maintenance payments, we concluded that the $83,000 in payments made to the one provider on behalf of the other two providers do not fit the definition of foster care maintenance payments, because the children in the care of these two providers did not reside with the provider who received the payments. Furthermore, we cannot substantiate that the provider who received the payments passed on the portion intended for the other two providers. Additionally, it should be noted that the one provider who received the payments for the other two providers acted as a subcontractor to the CPA but was not certified by the State. The standard state contract prohibits a CPA from entering "into any sub-contract without the express written approval of the Executive Director" of the Department of Human Services.

Payments to Employees and Contractors Questioned

We questioned the allowability of about $83,500 in payments made to CPAs' employees and contracted laborers for wages, bonuses, and reimbursements, which included:

- **Reimbursements of about $31,000 paid by a nonprofit CPA to its director and clinical director** were questioned due to the lack of documentation substantiating that costs incurred related to the provision of foster care services, as required by OMB Circular A-122.

- **A bonus of $25,000 was approved by a nonprofit CPA to its director** in Calendar Year 2001, despite the fact that the CPA's revenue decreased from the previous year and it operated at a significant loss in Calendar Year 2001. OMB Circular A-122 requires that when analyzing compensation paid to directors of nonprofit organizations, "determination should be made that such compensation is reasonable for the actual personal services rendered rather than a distribution of earnings in excess of costs."

- **Reimbursements of nearly $14,000 paid by two nonprofit CPAs to their employees** were questioned due to the lack of documentation substantiating that costs incurred related to the provision of foster care services, as required by OMB Circular A-122. Additionally, we questioned gasoline reimbursements paid by one CPA to its case managers and therapists. These payments were made at a rate of $50 per month per foster home supervised by the case manager or therapist. For instance, if a case manager or therapist supervised five homes in a month, this staff member would receive $250 for gasoline reimbursements. The CPA did not establish a written policy on this reimbursement and the same amount is paid

regardless of the location of the foster home. No mileage or other documentation is tracked to substantiate the reasonableness of these expenditures. According to OMB Circular A-122, Attachment B, Subparagraph 55(b), travel "costs may be charged on an actual basis, or a per diem or mileage basis in lieu of actual costs incurred, or a combination of the two." This CPA's method of reimbursing case managers and therapists for mileage is based neither on actual cost nor on a per diem or mileage rate. As a result, we have questioned all $4,400 in gasoline reimbursements paid to employees.

- **Payments of more than $7,500 paid by one for-profit CPA for contracted labor** were questioned due to the lack of documentation substantiating that costs incurred related to the provision of foster care services, as required by OMB Circular A-122.

- **Payments of $6,000 paid by one nonprofit CPA to a case manager** on behalf of a foster family for the purchase of a vehicle were questioned due to the applicability of the transaction to foster care. This CPA was withholding a portion of one of its foster care provider's child maintenance payments and remitting that portion to one of its case managers for the purchase of a vehicle by the foster parent from the case manager. While the foster care provider in question agreed to the transaction, child maintenance payments are supposed to be used by the foster parent to maintain a foster child in the home. We do not believe it is ordinary or necessary for a CPA to be involved in private party transactions between one of its certified foster parents and one of its employees. As a result, we have questioned the $6,000 paid to its case manager.

Controls Over Financial Activities of CPAs

The foster care system needs adequate controls to protect the interests of children and to safeguard the State's financial assets. The Department has been aware of the risks of misuses of foster care funds by CPAs for years. For instance, the 1998 Office of the State Auditor's Division of Child Welfare Services audit stated:

> It appears that as much as 65 percent of the total rate paid to CPAs for out-of-home placements may be used for administrative or other purposes beyond those related to the direct care and maintenance of the children in placement . . . Consideration should be given to the amount CPAs are retaining for administrative purposes and the amount being used for the direct care and maintenance of children in placement. At present, unlike many other publicly funded programs, there are no limits on what is spent or retained for administrative purposes. A

> 1997 review by the Department found that some CPA directors and their administrative staff receive more than $100,000 in annual compensation while other directors receive no compensation.

Additionally, a series of newspaper articles was released in 2000 that identified numerous financial issues related to CPAs. Despite these reports of actual or potential misuse of foster care funds, we encountered a system seriously lacking effective controls.

Department Audits: Although the staff from the Division of Child Care conduct on-site visits of CPAs during each year, they do not review the financial activities of CPAs. These visits primarily consist of reviews of safety and licensing issues. Further, we found that the Department's Field Audits Division does not conduct any financial monitoring of the foster care program. We believe it is critical for the Department to conduct in-depth audits of the financial activities of CPAs. The Department should use its Field Audits Division as a key component of ensuring private child placement agencies spend taxpayer funds appropriately. Fields Audits:

> . . . provides an external audit function for the Colorado Department of Human Services that independently verifies fiscal information. The primary responsibility of the unit is to ensure that those organizations receiving federal and state financial assistance have spent the funds in accordance with applicable laws and regulations . . . This function includes a sub-recipient [i.e., child placement agencies] monitoring component that meets federal mandates. . . . Field Audits also provides protection for CDHS against fraud, abuse and federal sanctions. The statutory basis for the Field Audit Division is found in the Colorado Revised Statutes. . . . Authority is also found in the Single Audit Act of 1984 (P.L. 98-502), the Single Audit Amendments of 1996, and OMB Circular A-21, A-87, A-102, A-110, A-122, and A-133.

The Department should develop and implement a risk-based approach to conduct comprehensive financial audits of a sample of CPAs over the next year. Following these initial audits, the Department should implement and establish an ongoing cycle to audit all CPAs.

Desk Reviews of Audited Financial Statements: Although CPAs are required to submit an annual independent audit to the Department each year, we found that the Department has not enforced this requirement. During our audit we requested the financial audit reports for the CPAs in our sample. The Department provided us with the audit report for only 1 of the 10 CPAs in our sample. Conducting desk reviews of the audited financial statements of CPAs can help Department staff to better identify unusual

expenditures that may represent misuses of foster care funds. A department regulation was changed effective February 2002 to now require CPAs to submit independent audits along with self-reported financial information to the Department. The Department's internal audit group plans to begin reviewing these reports and documents.

Reasonableness Tests: Because the Department does not conduct audits or desk reviews of financial transactions by CPAs, staff do not know if expenditures incurred by CPAs are reasonable. Some of the problems in our audit were identified using simple analytical review. For example, analyzing payments to foster care families in comparison to costs of therapy, case management, or overhead is a simple way to identify where problems may exist. The Department, however, compiles little information to allow it to check for exceptions and deviations. The Department should include these tests as part of its on-site audits and desk reviews.

Follow-Up and Enforcement: We found that the Department has not adequately followed up on concerns raised in the past. For instance, in May 2000 the Department attempted to identify how much money passed between a nonprofit CPA and its related for-profit corporation. However, due to the lack of information provided, the Department was unable to make this determination. A state inspection report dated May 11, 2000 recommended:

> Better documentation of the agency's income and expenses needs to occur. At present, it is still difficult to ascertain how much of the agency's revenues revert to [the related for-profit corporation] as opposed to remaining within [the CPA] to meet the needs of foster families and children in care. This has been a major risk factor for this agency in the past. In order to ensure that this does not reoccur, ongoing fiscal accountability of this agency to its funding entities is crucial.

Although state licensing staff noted concerns regarding this CPA, we found that the Department has made no effort since the May 2000 review to determine how much money passes between the CPA and its related for-profit corporation and whether these payments relate to the provision of foster care and are reasonable. The Department needs to require this CPA to make all of its financial records available for inspection, including all records related to payments between this CPA and its related for-profit corporation. The standard contract established between counties and CPAs includes a provision that permits the Department "to monitor the service program, fiscal books, and other records sufficiently to assure the purchases of services in the agreement are carried out for the benefit" of the foster care children. If this CPA refuses to provide these records, the Department should take immediate negative licensing actions against this CPA. Section 26-6-108(2), C.R.S., identifies several situations in which the Department can deny,

suspend, revoke or make probationary the license of a CPA as well as assess fines against the CPA. One of the criteria in which negative licensing actions can be taken and fines assessed is failure or refusal by the CPA "to submit to an investigation or inspection by the Department or to admit authorized representatives of the Department at any reasonable time for the purpose of investigation or inspection."

To date, the Department has not identified any questioned costs at any of the 61 CPAs. We believe the Department should work with the appropriate federal and county organizations to recover all of the misused funds by CPAs in our sample. The standard contract established between county departments of human/social services and CPAs states:

> Incorrect payments to the contractor due to omission, error, fraud, or misuse of funds shall be recovered from the Contractor either by deduction from subsequent payments under this contract or other contracts between the County and the Contractor or by the County, as a debt due to both the State of Colorado, Colorado Department of Human Services, and the County.

Further, to date, there have been no sanctions imposed on CPAs for misuses of public funds. According to management, the Department does not have the statutory authority to impose sanctions for misuse of funds. The Department's regulations state that a licensed CPA "may be fined up to $100 a day to a maximum of $10,000 for each violation of the Child Care Licensing Act or for any statutory grounds as listed at Section 26-6-108(2), C.R.S." This statutory provision identifies a number of circumstances in which the Department "may deny, suspend, revoke or make probationary" the CPA's license or assess a fee against the CPA. As stated in this section, the Department is authorized to take actions against a CPA for violations such as consistently failing to maintain standards prescribed and published by the Department or furnishing or making any misleading or false statements or reports to the Department. We believe the Department needs to seek statutory authority to impose fiscal sanctions for misuse of foster care funds.

(CFDA No. 93.658; Foster Care: Title IV-E; Activities Allowed or Unallowed, Subrecipient Monitoring.)

Recommendation No. 65:

The Department of Human Services should ensure that all child placement agencies providing foster care services are meeting state and federal requirements related to how public foster care funds can be spent. To accomplish this, the Department should:

a. Propose statutory changes to authorize the Department to impose fiscal sanctions against child placement agencies for misuse of funds.

b. Develop and implement a plan to audit a sample of child placement agencies within the next year. The Department should use a risk-based approach when selecting the sample of child placement agencies. The Department should report the results of these financial reviews to the Senate Health, Environment, Children and Families Committee and the House Health, Environment, Welfare and Institutions Committee by December 31, 2003. Following these initial audits, the Department should develop and implement a plan to audit child placement agencies on an ongoing cycle.

c. Enforce requirements that child placement agencies submit audited financial statements on an annual basis. The Department should review and analyze these financial statements and follow up with child placement agencies on any questionable expenditures.

d. Provide technical assistance and training to child placement agencies on the proper uses of foster care funds.

e. Work with the U.S. Department of Health and Human Services administrators to identify and recover all federal unallowable costs incurred by child placement agencies in our sample.

f. Work with the county departments to determine whether the findings set forth in this report constitute a breach of their contracts, and if so, seek appropriate remedies.

g. Assist county departments in seeking recovery of misspent funds by providing administrative and technical support as needed.

Department of Human Services Response:

Partially agree. Implementation: December 31, 2003. The Department will propose the statutory changes recommended. The Department will also develop and implement a plan to audit a sample of child placement agencies based on risk in the next year and will report the results of the review as outlined. The Department will also develop and implement a plan to audit a sample of CPAs on an ongoing basis. The Department will enforce requirements that child placement agencies submit audited financial statement and will provide technical assistance

and training on the proper uses of foster care funds. The Department will work with the federal Department of Health and Human Services as well as county departments in the recovery of unallowable costs.

Rate-Setting Approach

Rates paid by counties to child placement agencies vary significantly. Colorado statutes give county departments of human/social services the authority to negotiate monthly rates paid to CPAs. In 1997 the Colorado General Assembly modified the ways counties set foster care maintenance rates. Senate Bill 97-218 established provisions allowing counties to:

> Negotiate rates, services, and outcomes with providers if the county has a request for proposal process in effect for soliciting bids from providers or another mechanism for evaluating the rates, services, and outcomes that it is negotiating with such providers that is acceptable to the state department [of human services].

Prior to the passage of the Bill, the Department was responsible for setting maximum rates for foster care. When comparing the 1996 foster care child maintenance rates established by the Department with the rates currently set by counties, we found that, in general, the current county rates are higher than the Department's 1996 foster care rates.

The total monthly payment to CPAs for children in their care is based upon four rate components, which include:

- **Child Maintenance** is a reimbursement to cover the cost of maintaining a child in foster care, including a difficulty-of-care component for children who require increased supervision. Counties often determine these rates using standardized assessment tools. One of the most common tools used by counties is the Needs Based Care (NBC) instrument. This tool was created by the Northern Consortium of Counties as a mechanism for counties to negotiate rates with child placement agencies. County staff use this tool to identify how difficult it will be for providers to care for the child and, based upon this information, assign a level of care for the child, often ranging from 0 to 3. Each level of care corresponds with a monthly child maintenance rate.

- **Administrative Maintenance** covers general and administrative overhead, and case management services provided to children in foster care. Some counties

establish their own rates for this component. In our sample of seven counties, we found that five counties set their own administrative rates. Often, these counties either develop these rates based upon the results of the standardized assessment tool or establish flat rates to pay to CPAs for all children, despite their difficulty-of-care results. Counties that do not establish their own rates use the state-determined rates for this component, often referred to as the "anchor rates." In our sample of seven counties, we found that two counties use the state-determined anchor rates. Anchor rates are developed for each individual child placement agency licensed by the Department. The Department sets these rates based upon cost estimate reports prepared by CPAs applying for a license. These reports include personnel, office space, transportation, and other administrative costs that the CPA anticipates will be incurred when providing foster care services. Department staff use these cost estimates to determine the monthly administrative maintenance and services rates. According to department staff, approximately 90 percent of the anchor rates in the Trails system were established prior to 1997. These anchor rates have not been adjusted since early 1997.

- **Administrative Services** covers social services-type functions including therapeutic, recreational, and educational staff. These rates are established in the same way as administrative maintenance rates.

- **Respite** covers costs associated with the temporary supervision of foster care children. The State has set the monthly compensation rate for each child at $20.

CPA Rates Adjustments

We identified a number of problems with the rate-setting approaches used by the Department and counties to set administrative rates paid to CPAs. Specifically, the counties that set their own administrative rates do not base the rates on any type of cost analysis. For instance, one county merely requested that CPAs provide staff with the rate that would sufficiently cover their administrative costs. The county did not require the CPAs to provide documentation to support the rate request. Using the CPAs' requests, this county set a flat administrative rate to pay its CPAs. Another county reported that it requests from the CPA a summary of its costs. According to county staff, CPAs provide this summary informally over the phone, and no documentation is provided to the county to substantiate the costs reported by the CPAs.

By not setting their administrative rates based upon CPAs' individual cost experiences, counties may over or under compensate CPAs for their services. For instance, we questioned more than $420,000 in costs paid to a CPA in Calendar Year 2001. We

found that this CPA paid its foster parents high monthly maintenance payments, often passing on the entire maintenance amount paid by the county to the foster parents. After paying its foster parents, this CPA had enough foster care funds remaining to pay mortgages on various properties, disburse money to the owner's family members, and purchase personal items. This CPA was paid nearly $430,000 in administrative cost reimbursements in Calendar Year 2001. However, we determined that this CPA incurred administrative costs for the year of approximately $80,000, which included employee salaries, rental costs, and office supplies. Most of the counties that contracted with this CPA set their own administrative rates. Because these counties did not consider actual cost experiences related to foster care services, they did not account for the minimal administrative costs needed to operate this CPA.

Additionally, we found that had all the counties that contracted with this CPA in Calendar Year 2001 used the state-determined anchor rates, they would have paid this CPA more than $815,000 for administrative costs. One of the main problems with how the Department establishes anchor rates is that these rates are based upon each CPA's estimates of cost and caseloads at the time they are licensed by the State. The Department does not modify these rates after the CPA has begun its operations to better reflect the cost experiences and caseloads of the CPA. As we mentioned earlier, the vast majority of anchor rates entered in Trails were established more than five years ago.

It is essential that the Department and the counties reevaluate their methods for establishing administrative rates paid to child placement agencies. Administrative costs will vary from agency to agency, depending on the size of the organization and the range of services provided. Our review of the financial activities of a small sample of child placement agencies indicates that by not basing child placement agency rates on the cost experiences of the agencies, counties are paying some CPAs more than is needed to provide foster care services and are inappropriately using taxpayer dollars. Options for modifying the rate-setting approach include:

- **Establishing capped administrative rates for all CPAs at a reasonable percentage based upon analysis of cost data.** The Department would need first to collect and evaluate information related to the cost experiences of CPAs. Using this information, the Department could then determine a reasonable percentage that would allow CPAs to effectively and efficiently provide foster care services. Upon implementation of capped administrative rates, the Department would need to monitor the financial activities of CPAs to ensure that administrative costs are not exceeding the capped amount. If CPAs exceed the maximum amount allowed, the Department would need to take actions to recover the unallowed administrative expenditures.

- **Establishing statewide ranges of allowable administrative rates paid to child placement agencies.** Rather than capping administrative costs at a specified percentage, the Department could determine ranges of reasonable administrative rates that could be used by CPAs. To determine these ranges, the Department would need to conduct cost analyses of CPAs in the State.

- **Maintaining the current system of individualized rates for each CPA but centralizing the cost analysis to ensure reasonableness.** Under this model, the Department would need to conduct analyses of cost experiences of CPAs at least every two years and compare the results with how much counties are paying CPAs for administrative costs. The Department would need to be given authority to require counties that have set their administrative rates for a CPA too high to lower their rates to a reasonable amount, as determined through the cost analyses. Further, the Department would need to share the results of these cost analyses with counties so that they can use this information to make future decisions on administrative rates.

(CFDA No. 93.658; Foster Care: Title IV-E; Allowable Costs/Cost Principles.)

Recommendation No. 66:

The Department of Human Services should ensure that counties pay child placement agencies a reasonable level of compensation based upon their individual cost experiences. This should include:

a. Modifying the rate-setting approaches used by the Department and counties. This may include capping administrative costs incurred by child placement agencies, establishing statewide ranges of allowable administrative rates paid to child placement agencies, or maintaining the current system but enhancing the rate-setting procedures. Depending on how the rate-setting structure is changed, the Department may need to propose statutory changes that would reassign some of the rate-setting responsibilities with the Department, particularly the setting of administrative rates.

b. Collecting and analyzing information on licensed child placement agencies' cost experiences at least every two years and ensuring that administrative rates set by the Department and counties reflect these cost experiences. The Department should share its CPA cost analyses with all counties in the State. Further, if the rates are higher or lower than a CPA's administrative costs, the Department should adjust the rates.

c. Reviewing counties' methodologies for establishing administrative rates at least every two years to determine if they accurately reflect the cost experiences of CPAs. If the Department identifies counties that have set their administrative rates too high or too low, the Department should assist these counties in adjusting these rates to accurately reflect the costs of the CPAs.

Department of Human Services Response:

Partially agree. Implementation: July 1, 2003. With respect to (a), the Department disagrees with setting administrative caps or reassigning rate-setting to the Department. With the passage of SB 97-218 which capped the child welfare allocation, counties were given the ability to negotiate their rates in order to better control their costs. Regarding (b) the Department agrees to improve rate-setting by analyzing cost information and providing the results of the analysis to county departments. Additionally the Department will adjust the administrative rate in the system to be more aligned with the cost reports. The Department also agrees to review counties' methodologies for setting rates and as a result of the review will communicate either approval or denial of the rate-setting methodology.

Federal Title IV-E Reimbursements

We identified several instances where the Department failed to claim all of the federal Title IV-E funds available to the State. First, we found that the Department did not always correctly categorize child placement agencies' business designation (nonprofit vs. for-profit). The Division of Child Care is responsible for entering a child placement agency's business designation into Trails. We identified 23 nonprofit CPAs that were erroneously classified as for-profit agencies for all or a portion of Calendar Year 2001. According to department staff, the Division of Child Care has not verified the accuracy of the business classifications of CPAs as recorded in its automated systems for several years. The Department will not claim federal Title IV-E reimbursements for IV-E eligible children placed with CPAs classified as for-profit in Trails. This means that if the Department incorrectly classifies a nonprofit CPA as a for-profit, then the Department will not receive federal reimbursements on the child and administrative maintenance payments for IV-E eligible children in the care of the CPA. We estimate the State lost nearly $1.2 million in federal IV-E child and administrative maintenance reimbursements as a result of incorrectly classifying nonprofit agencies as for-profit. However, it should be noted that we identified a few instances where for-profit CPAs were incorrectly classified as nonprofits, and we estimate that nearly $150,000 in ineligible Title IV-E federal reimbursements were claimed.

The Department needs to review these business classifications periodically to verify that they are correct.

Second, we found that counties are placing IV-E eligible children in for-profit CPAs. As mentioned earlier, the State cannot claim Title IV-E reimbursements for the child and administrative maintenance payments made to for-profit child placement agencies. We estimate that the State lost more than $1.4 million in federal foster care maintenance reimbursements due to placing IV-E eligible children through for-profit CPAs. The Department should work with representatives from the U.S. Department of Health and Human Services to determine why states cannot receive IV-E reimbursement for children placed with for-profit CPAs and whether any flexibility in this requirement exists. Additionally, the Department should evaluate the costs and benefits of requiring CPAs to be nonprofit organizations and propose changes in statutes and regulations, as necessary.

Finally, we found that many counties are not properly entering foster care rates into Trails. As mentioned earlier, county payments to CPAs comprise four rate components: (1) child maintenance, (2) administrative maintenance, (3) administrative services, and (4) respite care. The Department uses the child maintenance and administrative maintenance components to determine the amount to claim for Title IV-E reimbursements. We identified 8 instances in a sample of 15 where the county-negotiated CPA rate components did not match the information reported in Trails. The Department requires the counties to make adjustments to rates in Trails based on the counties' negotiated rates with CPAs. If the counties do not adjust these rates, then the child maintenance amount will default to a lower level.

From analysis of Trails payment data, we found that many counties are not adjusting the child and administrative maintenance components to reflect the higher negotiated rate. As a result, the difference between the negotiated child maintenance rate and the rate entered into this component in Trails is being classified under the administrative services component. This means that the child maintenance rate claimed through the Title IV-E program for children eligible under this program is lower than it should be, and the administrative services rate component is being overstated. Costs classified under the administrative services component are funded partially through the Social Services (Title XX) Block Grant. Overstating administrative services draws funding away from other Title XX-funded programs. We were unable to determine the total amount of Title IV-E funds that the State did not claim as a result of these errors because we could not obtain all of the data needed to make this determination. We found that county staff are confused about the appropriate adjustments required in Trails for the rate components. Further, some county staff were unclear on which rate component should be used to categorize various CPA rates. County staff reported that they have not received training on how to properly enter rates into Trails.

State statutes emphasize the importance of accessing all available Title IV-E funds. According to Section 26-1-109(4.5), C.R.S., the Department shall "undertake necessary measures to obtain increased federal reimbursement moneys available under the Title IV-E program." As a result, it is essential that the Department take the necessary actions to ensure that all available Title IV-E funds are claimed by the State in the future. Further, the Department should submit retroactive requests for all federal Title IV-E reimbursements that were not claimed within the last two years. According to federal regulations, claims for reimbursements can be submitted to the federal government up to two years after the costs are incurred.

(CFDA No. 93.658; Foster Care: Title IV-E; Allowable Costs/Cost Principles.)

Recommendation No. 67:

The Department of Human Services should ensure it submits reimbursement claims that include all federal Title IV-E funds available to the State. To accomplish this, the Department should:

a. Work with counties to identify all Title IV-E costs eligible for federal reimbursement that were not claimed within the last two years. Upon identifying these costs, the Department should immediately submit a retroactive request to the federal government claiming reimbursements for these costs.

b. Verify that business classifications (nonprofit vs. for-profit) of all child placement agencies are properly entered into Trails. The Department should review the information in Trails biannually to ensure that it is accurate.

Department of Human Services Response:

Agree. Implementation: January 1, 2003. The Department will continue to work with counties to assure that eligible IV-E costs are retroactively claimed as appropriate. The Department will also review information in Trails to assure that providers' business classifications are accurate.

Recommendation No. 68:

The Department of Human Services should ensure that counties' placement and data entry processes result in the Department's accessing all of the federal Title IV-E funds available to the State by:

a. Working with representatives from the U.S. Department of Health and Human Services to determine why states cannot receive Title IV-E reimbursements for children placed with for-profit CPAs and whether any flexibility in this requirement exists.

b. Evaluating the costs and benefits of requiring CPAs to be nonprofit organizations and proposing changes to statutes or regulations, as necessary.

c. Issuing a written policy to all counties in the State that details how counties should enter foster care rates into Trails. In addition, the Department should provide technical assistance and training to counties on how to enter rates into Trails and monitor how counties are entering rates into Trails on an annual basis.

Department of Human Services Response:

Partially agree. Implementation: January 1, 2003. The Department agrees to work with Federal Representatives to determine if flexibility exists in claiming IV-E for for-profit CPAs. The Department will continue to provide technical assistance and training to counties on entering rates into Trails appropriately. The Department agrees to evaluate the role that for-profit CPAs fulfill in the public Child Welfare System.

Colorado Trails Information System

The Colorado Trails system was implemented in 2001 to meet new federal reporting requirements for children in adoption and foster care. With respect to State Child Welfare programs, the Colorado Trails system includes Adoption and Foster Care, the Central Registry of Child Protection, and licensing and certification of child care providers. Payments to providers including foster care homes, residential treatment centers, adoptive parents, and child care providers are made through Trails on behalf of children in these Child Welfare programs. Trails is part of an integrated data system within DHS with interfaces to the State's eligibility system for public assistance and Medicaid programs, as well as various other information systems. Trails also interfaces with the County Financial Management System (CFMS), which links county financial systems to the State's financial system, COFRS.

The following comments were prepared by the public accounting firm of Ernst & Young LLP, who performed audit work at the Department of Human Services. The comments were contained in the *Colorado Department of Human Services, Colorado Trails System Performance Audit*, Report No. 1456, dated November 2002.

Data Integrity

In order for any system to be effective, the user must be able to rely on the data integrity of the information maintained within that system. For example, the system should be able to accurately calculate amounts such as payments and create reports based on the data within the system. The main concern with Trails is the lack of data integrity of the system. The problems with data integrity impact a number of the other areas discussed in this report, such as fiscal issues and system reports. The findings below document the current data integrity issues.

Duplication of Records

Trails is a sensitive application requiring users to enter information according to exact specifications. Additional controls need to be in place to identify or prevent errors. When errors are inadvertently made, they are processed through the system and affect case information and reporting. The major concern regarding data integrity is the duplication of clients and providers within Trails.

In order for the system to process data correctly and produce accurate reports, each client and provider should only be entered once. County workers can use Trails' search engine to check for existing records to see if the client or provider is already in the system. The search engine contains features to aid in the search, such as "Soundex" and "Starts With". The "Soundex" feature will look for names that sound similar to the name entered. The "Starts With" feature will look for names beginning with the same letters as the name entered. These features are intended to help the user determine if the record already exists, even if the user misspells the name.

However, we found that unless thorough search processes are performed, inaccurate results are produced. For instance, if users attempt to search for a client using the full last name and the "Starts With" feature, they will probably find no match. If they use the first 3 to 5 letters of the last name and the "Starts With" feature, they will obtain a list of possible matches. The "Starts With" feature is a newer addition to the search engine; users are not familiar with how it works since earlier training session did not cover this feature.

The training center has established step-by-step procedures for conducting a thorough search, including searching other state systems. This search process can be time consuming, and therefore many users do not perform a complete search.

In the case of providers, Trails provides an additional control over provider searches by automatically listing possible duplications before a provider is added to the system.

However, we found that many of the county users were not familiar with the process and do not understand some of the system messages intended to prevent duplication of provider records. This prevents the control from operating effectively.

Although the search capability of Trails was intended to prevent or minimize duplication of clients, the application does not force users to perform a search, therefore users can add new clients or providers without considering information already entered. During our review, we found that most counties we visited had an extensive number of duplicated clients and providers in the system. While no definite number of duplicates on the system could be obtained, based on conversations with the counties, there are a significant number of duplications within the system. There is currently no process in place to identify possible duplicate records, once they have been entered.

Counties usually identify duplicates during processing of the case, for example, when payment problems occur, when creating reports or when applying for Medicaid on behalf of a client. In order to merge or combine the duplicate records, counties must identify all possible duplicates for that client or provider and combine the information from each duplicate record into one record. This process is time consuming, taking anywhere from 15 minutes to hours. Duplicate records are primarily the result of inadequate search engine capabilities and inconsistent search processes and techniques used by Trails users.

We also identified weaknesses in application input controls that add to the problem of duplicate records. According to application design documents, Trails is designed with controls to prevent the entry of duplicate social security numbers or state ID numbers and to disallow non-alpha characters in names.

We attempted to input incorrect data on the Trails test environment using the Trails design document and our understanding of the established input controls. Based on our basic tests, we noted the following:

- We were able to assign the duplicate social security numbers.
- We were able to assign social security numbers using only 9's or 0's or 1's (e.g., 999-99-999). Social security numbers must contain more than one numeric character.
- We were able to input a client name using only punctuation marks (!...#%&) or with numbers.

Duplicate records can have a significant negative impact on clients and providers, including the delay of timely treatment for clients and incorrect payments to providers. Duplicate

records also raise information integrity issues because it may be unclear as to which record is the official record in the case of court proceedings.

(CFDA Nos. 93.658, 93.659; Foster Care: Title IV-E and Adoption Assistance; Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Reporting.)

Recommendation No. 69:

The Department of Human Services should eliminate duplicate records within Trails and enhance input controls by:

a. Performing regular search processes to identify possible duplicate records within the system, communicating results of these searches to the counties, and developing procedures to ensure that corrections of duplicate records are made timely.

b. Providing training to counties regarding the process of communicating duplication errors to the State for correction and providing training to county information systems staff in order that county staff can perform consolidation or merges of duplicate records.

c. Following up with counties to ensure counties are actively resolving duplications, either by notifying the Department of duplicate records or by correcting duplicate records at the county level.

d. Implementing an outlined, specific methodology for county staff to use during the search process. County staff should be trained on this methodology and the importance of doing the process thoroughly.

e. Enhancing the system's search engine to better recognize similar spelling and shortened names.

f. Implementing detection controls, such as not allowing duplicate Social Security Numbers or State Ids.

g. Establishing a process where referral information without a valid social security number would be considered a temporary record and would be excluded from certain reports and processing.

Department of Human Services Response:

Partially Agree.

a. A reporting process to identify possible duplications within Trails has been in place since January 2002. This process is run bi-weekly and reviewed by the Trails staff. Clients within Trails are not county specific. We will modify the report to identify which counties have added the client to a referral, assessment or case. The Department will complete the above change and begin distributing the report on a weekly basis to the counties beginning February 2003.

b. A process has been in place since the completion of the rollout of Trails in May 2001 to eliminate duplicate records in Trails. Additionally, enhancements are being made to Trails to identify potential duplicate records to the users before a client record is added to the system. These enhancements are scheduled to be completed by March 2003.

c. Training has been made available on a limited basis to counties interested in doing their own merges. We will expand this process to all other counties by June 2003.

d. This training has been available to the counties since the implementation of Trails. Additionally, user desk guides have been provided to Trails users that outline the search methodology.

e. Enhancements were identified for the search engine. These have been presented to the state and county user groups for prioritization at the July 2002 meeting.

f. Enhancements for additional detection controls will be presented to the state and county user groups for prioritization at the January 2003 meeting.

g. At the referral stage, limited information may be known for a client. It is important to track referrals and assessments through the system from the very beginning to ensure that the child is properly protected and for the system to comply with state and federal regulations. However, a design review of when a client should be added to the centralized client database will be conducted. The results will be presented to the state and county Trails user groups for review and prioritization in February 2003.

Fiscal Issues

Trails contains a fiscal module that periodically creates a file containing provider payment information. This information is uploaded into the County Financial Management System (CFMS), which results in payments being issued to providers in the form of electronic fund transfers. The payment file generated from Trails is referred to as the provider payroll. Provider payrolls are created based on service dates, rates, and child placement information entered into Trails by county workers.
Counties run a trial provider payroll on an "as needed" basis and review payments for accuracy based on invoices and prior remittances to providers. The counties will make corrections to the payroll based on these reviews. Corrections must be posted before the payroll is run. Provider payroll is automatically processed through an interface with CFMS, and providers are paid on the 15th of each month.

Currently, Trails pays primarily for providers in the foster care, kinship placements, residential treatment centers, and subsidized adoption programs. Plans are in place to pay all other CORE services, such as mental health treatment, therapy and daycare through Trails.

The counties have encountered numerous problems when processing provider payrolls through Trails. These include improper provider payments, changes in funding source codes, provider rate changes, provider name changes, child name changes, service date changes, and most notably, interface issues with the CFMS system.

CFMS Interface with Trails

Trails can create credits and debits through the provider payroll process in order to adjust for the length of time that a child has been placed with the provider or other factors. The current process matches provider information from Trails to CFMS by provider name and tax ID number or social security number. If a match is not found within CFMS for both the provider name and tax ID number or social security number, CFMS will create a new vendor record and process the payment. In cases where the provider name has changed, this can cause outstanding credits within the CFMS system that are not associated with the previous provider name.

For example, if a provider has an outstanding credit, or overpayment of $100 within CFMS, this amount should be deducted from the provider's next payment. However, if that provider's name was changed within Trails (e.g., through marriage or an organization name change), CFMS will not be able to match both the provider name and tax ID or social security number. Therefore, CFMS will issue the payment under a new vendor

number, causing the provider under the new name to be paid the full amount without deducting the outstanding credit of $100 under the previous name.

This situation is further compounded by the fact that previous payments are sometimes "taken back" from providers when their names are changed within Trails, or in adoption cases when the child's name changes. CFMS holds all the fiscal history, including payment information, for each vendor or provider. When a provider's or a child's name is changed within Trails, CFMS treats the past payments under the previous provider name as an error and creates a credit in both CFMS and the Trails system for the past payment amounts. CFMS will then pay the provider under the new name for the amounts previously paid under the old provider name, thereby causing the provider under the new name to be overpaid. For example, in one case we noted, a county worker changed the provider's name from the wife's name to the husband's name. The worker typed the new name and social security number over the previous provider's information screen. This caused CFMS to issue a credit against all the funds previously paid under the wife's name, in effect taking back all previously issued payments under the wife's name. The prior payments were then paid again under the husband's name. In other words, the husband was paid for both the current period and all of the past periods. The Department reports that it pays out approximately $13.5 million dollars each month to providers throughout the State. The Department has calculated as of July, credits held with CFMS indicate that providers owe the DHS $650,000 for inaccurate payments.

In March 2002, DHS developed procedures instructing counties to use the "Unpaid AP Invoices Detail" report generated by CFMS to identify outstanding credits and possible duplicate providers within CFMS. The Department relies on the counties to provide instructions as to which providers within CFMS should be consolidated. DHS will then perform the consolidation of those duplicate providers within CFMS.

Per the Department, approximately 400 duplicate provider records have been identified and corrected to date.

In addition to the interface problems, we noted that controls over provider payments need to be enhanced. Currently CFMS does not have a range check to identify unusual or large payment amounts. This means that any amount requested through Trails for payment can potentially be paid. CFMS or Trails should have controls or reports that will identify excessive payments to an individual provider. Payments over established limits should be suspended until county workers confirm that the amount is accurate. County workers should review these over the limit reports in order to identify significant variances, and investigate and resolve these variances prior to issuing provider payments. These enhancements will help prevent potential overpayments.

The interface problems between Trails and CFMS and the lack of adequate controls present the potential for fraud, abuse, and irregularities to occur within the Child Welfare program. The Department should address these concerns as soon as possible.

(CFDA Nos. 93.658, 93.659; Foster Care: Title IV-E and Adoption Assistance; Activities Allowed or Unallowed, Allowable Costs/Cost Principles.)

Recommendation No. 70:

The Department of Human Services should take immediate steps to investigate and resolve the $650,000 in outstanding credits within CFMS and recover all overpayments. In addition, the Department should test a sample of provider payments made through Trails and CFMS to determine the accuracy and validity of payments issued on the basis of Trails data. All exceptions identified should be investigated and resolved. The results should be evaluated to determine the need for more extensive testing of provider payments.

Department of Human Services Response:

Agree. The Department agrees that it is important to recover the overpayments. As these issues have been identified, the Department has worked and continues to work with the counties to resolve them. As of October 2002, the total amount outstanding had been reduced to $592,000. Additionally, Trails generates on average $13,600,000 in payments a month. During the same period generating the $650,000 in overpayments (June 2001 to July 2002), Trails generated $191,000,000 in payments, or in other words, the overpayments represent less than one-half of 1 percent (0.3 percent) of the total payments paid out for the period.

Existing county and state reports are available through CFMS and Trails and provide the necessary information needed to identify and resolve provider payment problems. We continue to work with the counties to determine the accuracy and validity of their payments. A number of the services recorded in Trails have been evaluated against what was paid through CFMS. These payments proved to be accurate and valid.

The Department recognizes that accurate payments to providers are critical. Prior to any release of Trails, extensive testing is conducted within the fiscal area to ensure that the provider payments are being generated accurately. Implementation date: June 2003.

Recommendation No. 71:

The Department of Human Services should address interface problems between Trails and the CFMS and improve controls over provider payments by:

a. Implementing modifications to correct provider matching between the two systems. Provider information should be matched using one unique identifier such as the tax ID number or social security number.

b. Working with counties to establish provider limits that would be included on the trial payroll, allowing counties to identify excessive payments prior to the final payroll process.

c. Creating standard reconciliation processes to reconcile payments calculated from Trails to payments disbursed by CFMS. Procedures should include collection of any overpayments. Both the counties and the Department should be involved in the reconciliation and collection process.

Department of Human Services Response:

Partially Agree.

a. A change was made in both CFMS and Trails in September 2002 to address this issue. The results of the changes have been effective and are operating as prescribed. 193 duplicate provider records remain to be corrected and work continues on correcting them.

b. This recommendation will be presented to the County Trails User Group at their February 2003 meeting for consideration and prioritization for a modification within Trails.

c. CDHS accounting staff currently reconcile Trails payments to the CFMS general ledger. The Trails payment reconciliation was expanded to include reconciling Trails payroll amounts to Citicorp beginning with the July 2002 period. CDHS will make available to all counties completed reconciliation support via e-mail. According to Volume 7 rules, the counties are responsible for the collection process. CDHS has and will continue to assist the counties with this process.

Funding Source Changes

The funding source code associated with each service a client receives indicates the parties responsible for funding the provider payments: the county, state, or federal government. Within Trails the default code is "WRI" (without regard to income), which indicates the state and county are responsible for the provider payment; these cases are nonreimbursable by the federal government. For cases with "IV-E" funding source coding, the services qualify under the federal Foster Care program and the federal government will reimburse a percentage of the cost. County fiscal workers check the trial provider payroll to ensure that the correct funding source code is applied to each service prior to processing the final provider payroll.

In some instances, the funding source code in Trails is erroneously changed by the system from IV-E to WRI during the final payroll process. When this occurs, counties must undergo a lengthy investigation and a time-consuming request process by completing the State Administrative Adjustment (SAA) request form to receive the correct reimbursements. These changes to funding source codes appear to be caused by early problems with how Trails was reading funding source information. Under the legacy CWEST application, which was a client-based system, each client could only be associated with one funding source code. Within Trails, which is a case-based system, each client can have multiple funding source codes based on the number of services the client is receiving. In other words, in Trails eligibility workers can assign different funding codes according to the different services the client receives, rather than by client. In order to ensure that the correct funding source code is used for the provider payroll, Trails performs a selection process based on a pre-determined code hierarchy.

Prior to May 2001, Trails was incorrectly reading this funding source code hierarchy for cases converted from the CWEST system. This caused unintended funding source code changes to occur during the provider payroll process. A modification addressing this problem was installed in May 2001, which remedied these types of errors. However, for existing cases as of May 2001, the modification was activated only when a change was made to some aspect of the case, for example, if a child was placed with a different provider or the provider's payment rate was changed. There are a number of cases that existed prior to the modification in May 2001 that have not had any change made to them. When a change is finally made to one of these older cases, the May 2001 modification should initiate and make the necessary corrections to the current service codes only. However, we noted that when a case has an IV-E funding source code, Trails is incorrectly reversing the source codes back to the conversion date, instead of just correcting the current codes.

Inaccurate funding source codes result in provider payments being funded by the wrong source of funds. For example, if a case is erroneously coded WRI, the county and state will pay for services that should be funded at least in part by the federal government. Similarly, if a case is erroneously coded as IV-E, the federal government is improperly charged, which would result in disallowed costs to the State.

(CFDA Nos. 93.658, 93.659; Foster Care: Title IV-E and Adoption Assistance; Activities Allowed or Unallowed, Allowable Costs/Cost Principles.)

Recommendation No. 72:

The Department of Human Services should ensure that funding source codes are accurate in the Trails system by:

a. Implementing a system modification to prevent IV-E codes from being incorrectly reversed. Modifications to correct the problem should be tested to help ensure correct funding codes are not adversely affected.

b. Requiring that counties submit funding source codes adjustment forms for all errors identified and following up on all such requests in a timely manner.

c. Providing training to all fiscal staff and caseworkers to ensure counties are appropriately entering funding source codes. Training should use "real" life examples and include time for feedback and questions.

Department of Human Services Response:

Partially Agree.

a. A system modification was implemented and the Department believes this issue has been resolved. The Department will continue to research and respond to any future report of problems in this area. Regression testing of Trails is part of the standard process of the Department. Additionally, we have invited counties to participate in the regression testing prior to a release of Trails to ensure that existing functionality is not impacted by the changes being implemented. This was instituted in December 2001.

b. The State Administrative Adjustment (SAA) process through CFMS has been in place since the rollout of Trails. Counties have the responsibility to complete

SAAs through an online form in CFMS when an automated entitlement change cannot be made through Trails. This is not a form maintained in the services record. The CFMS entry is maintained online until processed. Once processed, the entitlement change can be verified by reviewing the child fiscal history report in Trails.

c. The Trails training group has been offering a Fiscal specialty training course and an Exploring Fiscal workshop every month since October 2001.

Provider Payroll Suspensions

County fiscal workers have the ability to suspend provider payments. However, if a caseworker goes into the case while a payment is in suspense and makes any changes to the record, the payment will be automatically be approved, thus invalidating the suspended status. This can cause invalid payments to be issued to providers.

(CFDA Nos. 93.658, 93.659; Foster Care: Title IV-E and Adoption Assistance; Activities Allowed or Unallowed, Allowable Costs/Cost Principles.)

Recommendation No. 73:

The Department of Human Services should enhance the Trails system so that changes made by caseworkers do not cause a suspended provider payment to be inadvertently approved.

Department of Human Services Response:

Agree. Original design of Trails called for all payments to default to unapproved versus approved. The county fiscal worker would then approve the payments for the payroll processing. However, input from state and county users indicated that it would be more efficient for the county fiscal worker if they only had to identify the payments not to be paid. Therefore, the default for payments was changed to approved. A modification request for the above recommendation was submitted in July 2002 to the state and county Trails user groups and is being prioritized by these groups.

Improper Provider Payments

During our review we noted several instances where provider payments were incorrect or duplicated, and the cause for the problem had not yet been determined. In one example, we noted a provider placement was end-dated in November 2001, yet the provider was still receiving payments. The county opened a helpdesk ticket, but the exact problem has not been identified. In another case, a provider was receiving a duplicate payment under one service code. Again, it was unclear what caused this situation.

(CFDA Nos. 93.658, 93.659; Foster Care: Title IV-E and Adoption Assistance; Activities Allowed or Unallowed, Allowable Costs/Cost Principles.)

Recommendation No. 74:

The Department of Human Services should ensure system problems with provider payments in Trails are addressed by:

a. Requiring that staff report all instances of improper payments to the Trails helpdesk.

b. Requiring that the helpdesk notify all counties when system problems are identified.

c. Requiring that the helpdesk provide additional instructions to the worker and relay these instructions to the other counties, when user errors are identified. In cases where overpayments have occurred, the Department should work with the counties to help ensure that these amounts are recovered.

Department of Human Services Response:

Agree.

a. It is the established procedure that any problems or issues with Trails must be reported through the CDHS Helpdesk before the problem will be addressed.

b. The Helpdesk utilizes a list server to notify all Trails' county contacts when system problems are identified.

c. The Helpdesk will develop processes and procedures to provide information to users concerning user errors by June 2003. Additionally, the information will be forwarded to the Trails Training group for incorporation into the Trails training courses. According to Volume 7 rules, the counties are responsible for the collection process. The Department will continue to assist the counties with this process.

System Requirements and Reporting

The Department of Human Services must have the ability to produce various reports and assessments to satisfy court, state, and federal requirements. These include federal requirements for Statewide Automated Child Welfare Information Systems (SACWIS), Family Service Plans (FSP), assessments related to Child Welfare, the Adoption and Foster Care Analysis and Reporting System (AFCARS), and the National Child Abuse and Neglect Data System (NCANDS). In order to manage cases and administer the Child Welfare program, counties must track caseloads by caseworkers, opened and closed cases, placements with each provider, and other information for analysis and case management. In addition, the counties must have the ability to generate reports in order to receive funding from state and federal sources as appropriate. In addition to standard reports, Trails can be used to generate ad hoc reports with county-specific data.

The reporting process within Trails does not provide accurate data and does not fully meet various state and federal requirements. In addition, the system does not provide accurate information to the counties for case management purposes.

Adoption and Foster Care Analysis and Reporting System (AFCARS) Requirements

The Department's system for managing information under the Foster Care and Subsidized Adoption programs, known as AFCARS, must meet various state and federal requirements. These include documentation on the removal of children from the home and children's disabilities and cultural needs. However, this information is not consistently documented in Trails because many workers are not clear on where to record these items. This results in inconsistencies in the documentation process of AFCARS requirements among counties. Additionally, certain required AFCARS fields, such as the end dates for removal of children from a home, are routinely altered as part of workarounds to compensate for Trails' functional deficiencies with respect to issuing provider payments to foster care parents and to families receiving subsidized adoption payments.

Ad Hoc Reporting

Ad hoc, or user defined reports are created by running a query against a database or a collection of data, and can be run at anytime by users with access to the query tools. Predefined reports, on the other hand, are based on predetermined logic and cannot be altered by the average user. Counties have the ability to run ad hoc reports, but counties are limited to a filtered view of only that county's information.

During our county visits we observed the county Information Systems groups running ad hoc reports. We noted that reports contained duplicate client information or did not contain complete information. One report generated on the number of open referrals for services for the month only showed four referrals for the county, when in fact there were over 100 referrals noted. This problem appears to be due to the filtered view on which each county's reports are generated, which limits the information in Trails that can be accessed for ad hoc reports. County workers reported that when the same ad hoc reports are run by the State's Information Systems group using the entire Trails database, the reports appeared to be more accurate.

Case Management Requirements and Funding Information

Because of problems with obtaining accurate and complete information, several counties are entering data into separate databases outside the Trails system in order to produce accurate reports on caseloads and assignments. Accurate information is needed in order for the counties to submit caseload data to the state and federal government and receive funding from those entities. This double entry of data increases counties' workloads and opportunities for input errors.

Court Requirements

Our review also noted that Trails does not provide adequate reporting functionality to satisfy court requirements. For example, several counties do not utilize the Family Service Plan (FSP) reports because Trails does not provide formatting accepted by the courts. Currently, each court requires Child Welfare information to be formatted differently. Also, documents needed by the courts such as risk assessments, safety assessments and the North Carolina Family Assistance Scale screens within Trails cannot be printed as reports. Therefore, staff must manually write out this information and calculate results in order to provide it to the courts.

In addition, Trails reports that are generated for court purposes have to be printed out in their entirety and cannot be limited only to sections that are of interest or required by the courts.

Other Factors Affecting Reporting

Other issues discussed earlier in this report add to the inaccuracy of the Trails reporting, such as the duplication of client and provider records within Trails (Data Integrity Section). Reporting errors also occur as a result of caseworkers entering invalid dates and information as "workarounds" in order to force Trails to process cases timely (Fiscal Issues Section). Additionally, each time a case is transferred to another worker, the application associates that client with each worker; therefore the same client will appear multiple times in the report under different caseworkers.

Overall, the inability of Trails to produce adequate reports has resulted in the continued use of manual procedures and processes. Furthermore, if counties are completing risk or safety assessments for children or families offline, other counties will be unable to view the complete file of a client. This results in county workers making phone calls and sending hard copies to other counties to share the information. Finally, by completing child assessments both online and manually, there is some risk that assessments may not be prepared or scored exactly the same in both instances. This could have an impact on the integrity of information available for decision-making and thus affect the services and treatments provided to clients.

In general, the lack of accurate reports and the need for users to maintain two sets of data is a poor use of personnel resources, undermines user acceptance, and does not meet the basic goals of Trails to provide a statewide system for case management and streamline record keeping and service delivery, while meeting the required reporting criteria.

(CFDA Nos. 93.658, 93.659; Foster Care: Title IV-E and Adoption Assistance; Reporting.)

Recommendation No. 75:

The Department of Human Services should ensure reports from the Trails system are accurate and meet requirements by:

a. Providing specialized training to appropriate county workers on reports, including instructions on AFCARS and NCANDS requirements.

b. Working with the counties and other stakeholders to identify critical reports and other reporting issues, such as court-required formats and ad hoc reporting limitations. The Department should establish agreed upon priorities and timelines for addressing reporting concerns.

c. Establishing procedures to solicit courts to accept one established format for court documents.

Department of Human Services Response:

Agree.

a. A specialty training course on Trails Reports has been offered each month since October 2001. The Department is meeting the federal reporting requirements for both AFCARS and NCANDS. Currently, the inaccuracies are contained within five or fewer of the 100 data elements. We are continuing to improve training, understanding by the users and the programming that generates these reports to eliminate these inaccuracies.

b. A reports workgroup was formed in June 2001. The results of the workgroup were given to the County Trails User Group in July 2002 to prioritize the issues. Since November 2001, the Department has met regularly with the county-designated ad-hoc reports group to discuss and develop ad-hoc reports desired by the counties. The ad-hoc reporting database will be changed by February 2003 to give the counties a full view of the data.

c. We will establish procedures by March 2003.

Medicaid Issuance

Trails allows caseworkers to request and document Medicaid services for a client. However, in some instances the information in Trails is not consistent with critical information related to Medicaid eligibility held by the State's Client Oriented Information Network (COIN) system or the Medicaid Management Information System (MMIS).

During our review we noted an instance in which Trails indicated that a child was Medicaid-eligible, but the MMIS system classified the child as being covered by third party insurance and therefore not eligible for Medicaid.

The interface between Trails, COIN, and MMIS should be improved to reflect consistent information on a child's eligibility for Medicaid.

(CFDA Nos. 93.777, 93.778; Medicaid Cluster; Eligibility.)

Recommendation No. 76:

The Department of Human Services should continue to work with the Department of Health Care Policy and Financing to improve the interface between Trails, COIN, and MMIS, in order that Medicaid information is accurately reflected in all State systems.

Department of Human Services Response:

Agree. The Department will continue to work with the Department of Health Care Policy and Financing to improve the interface between Trails, COIN, and MMIS for Medicaid information. All reported problems are researched by the three areas. Additionally, the Trails staff is working with the CBMS staff to identify the modifications required in both systems to support the interface with the advent of CBMS.

Department of Health Care Policy and Financing Response:

Agree. Clients may have third party insurance and still receive Medicaid. However, in this case, the client could have been inappropriately classified as not eligible for Medicaid. The Department agrees that ensuring accurate data in all state systems is important and will work diligently with Department of Human Services to improve the data.

TANF Diversion Program Overview

The purpose of the Temporary Assistance for Needy Families (TANF)/Colorado Works program is to assist needy families with dependent children to obtain and sustain self-sufficiency through time-limited cash payments. TANF regulations allow states to provide lump-sum, non-recurring cash payments to families rather than recurring monthly basic cash assistance (BCA) payments. These short-term benefits are intended to address a family's specific crisis or episode and assist the family in maintaining or gaining employment, and thereby divert the family from requiring long-term assistance. Some examples of short-term needs that could qualify under diversion are car repairs, apartment security deposits and rent, and utilities. In 1997, Colorado created two Diversion Programs for families with short-term needs: state diversion and county diversion.

The Department of Human Services is the primary recipient of the TANF federal grant award. In large part, the Department passes these funds through to county departments of social services. These local departments are responsible for administering the Colorado Works program within their county under the terms of the county under the terms of the county's performance contract with the State. Under federal regulations, the Department is responsible for monitoring the activities of the county departments to ensure federal awards are used in compliance with laws, regulations, and the provisions of grant agreements and that performance goals are achieved. Thus, the Department is responsible for the oversight of the TANF/Colorado Works Program and compliance with federal requirements. Within the Department, the Office of Self-Sufficiency (Office) oversees the program. Statutes give the 64 county departments of social services broad authority to administer Colorado Works under the Department's supervision.

During Fiscal Year 2002 the Office of the State Auditor conducted a performance audit of the TANF Colorado Works Diversion Program. The audit comments below were contained in the *Colorado Works Diversion Program, Department of Human Services, Performance Audit* Report No. 1455, dated August 2002.

Diversion Payments and Compliance with Regulations

As discussed, a state or county diversion cash payment should be a nonrecurrent payment to a recipient to assist the family in dealing with a specific crisis situation or episode. Federal regulations for "nonassistance" (i.e., payments that are not considered "assistance," such as basic cash assistance payments), which apply to Diversion Programs, required that diversion payments be directed toward recipients who do not need long-term assistance. Recipients must demonstrate a need for a particular type of assistance. Federal and state regulations do not clearly define the specific types of needs that may be met by Diversion Programs. However, federal regulations do prohibit the use of TANF funds for some types of costs, such as medical services other than prepregnancy planning services and capital construction, as well as payments made to fugitive felons.

To evaluate the implementation of the TANF Diversion Program in Colorado, we selected a sample of case files for review. Overall, we identified problems with 77 of the 239 cases in our sample, or 32 percent, and a total of $94,000 in questioned costs.

We found a total of 30 cases in which diversion payments made by the counties were not consistent with federal and/or state requirements (some payments had more than one problem and appear in more than one category).

- **In one case, the county provided county diversion payments totaling $5,400 from November 2000 through September 2001 to a family in which both parents were fugitive felons.** Of these payments, $4,800 was provided to the family after the information on the recipients' arrest warrants was obtained by the county. Both federal and state regulations prohibit payments to fugitive felons.

- **In 11 cases, with payments totaling $41,000, the families did not meet the appropriate income requirements for the diversion payments they received.** Three of the eleven families had income exceeding the county-established guidelines for county diversion and thus were not eligible for either state or county diversion payments; these recipients received $14,200 in county diversion payments. The other eight received almost $27,000 in county diversion payments but were only eligible for state diversion or basic cash assistance.

- **In 4 cases, families received a total of $7,232 after county staff determined the recipients were not complying with specific components of their federally-required Individual Responsibility Contracts (IRC).** According to state laws and regulations, in order to receive a diversion payment, each recipient is required to sign an IRC that outlines the county's expectations and terms the client must meet to receive assistance.

- **In 7 cases, counties provided payments totaling $3,279 for medical services including hospital bills, prescriptions, and miscellaneous unspecified medical bills.** According to federal regulations, TANF funds are not to be used for medical services other than prepregnancy planning services or limited medical costs previously allowed by the State under the federal JOBS program.

- **In 9 cases with payments totaling $14,344, the families did not appear to be appropriate candidates for diversion.** Our review of case file documentation indicated these recipients had no current or future job prospects or otherwise had ongoing, long-term needs that would not be met by short-term diversion payments. Therefore these payments did not qualify under state regulations requiring that diversion participants not have a need for long-term cash assistance.

In addition to these compliance issues, we noted that not all counties in our sample had a policy requiring that efforts be made to recover overpayments under diversion. We identified 3 cases in which families received overpayments totaling $12,160 due to caseworker error. According to department staff, recoveries are not required under federal law, state statutes, or state regulations; recovery efforts are only required for

overpayments of public assistance. Federal rules classify diversion payments as "nonassistance," and the Department considers diversion participants to have been "diverted" from public assistance (i.e., from basic cash assistance). Thus, the Department does not require that counties include recovery policies for state or county diversion as part of their county plans for Colorado Works. Nonetheless, we noted that in one instance a county did attempt to recover a diversion overpayment.

Finally, in 28 cases we identified payments totaling approximately $33,000 (not included in total questioned costs of $94,000) for mortgage payments and related late fees, sports equipment, driving fines, furniture, cable television, a television set, a computer, personal loans, and past due credit card bills. While payment for these needs is not specifically prohibited by Colorado Works regulations, these purposes appear to represent recurring and/or nonessential needs. Documentation in the case file did not substantiate that these needs represented crisis situations that would be appropriately met through diversion payments. In addition, the counties we visited had varying beliefs regarding whether payments for these types of purchases in general were allowed or otherwise appropriate.

Diversion Payments Controls

While the Department has established various controls over the Colorado Works program, these findings indicate that the controls over the diversion component of the TANF/Colorado Works program are not adequate. First, the Department does not routinely review diversion payments to assess adherence to the legislative intent of the program or for otherwise ensuring counties are meeting program requirements. This review could be accomplished in two complementary ways.

- The Department should review actual case files of diversion recipients on a periodic basis. This should be done as part of the Department's ongoing on-site reviews of Colorado Works at county departments. With respect to these on-site reviews, in our Fiscal Year 2001 financial audit of the Department, we found that the Department had discontinued these monitoring visits for Colorado Works. That audit recommended that the Department reinstate this review process, including case file reviews, in order to identify problems in areas including eligibility determination and benefit payments. The Department agreed with this recommendation. During this audit of the Diversion Program, the Department provided us with the plan and schedule it had developed to perform on-site monitoring at the counties on a four-year cycle for the Colorado Works program. The first of these visits was scheduled for June 2002.

  It is imperative that diversion case files be included in those reviewed during site visits. Many of the problems identified in our audit of state and county diversion,

in both this section and later sections of this report, could have been identified and resolved by the Department–and perhaps prevented–if it had an ongoing monitoring process in place to review diversion case files. These reviews should include follow-up discussions with county staff regarding any findings or questions and resolution of any problems. During this process the Department can also obtain information to identify trends, best practices, and areas in which technical assistance is needed.

- In addition to performing on-site monitoring, the Department should review diversion payments by performing analytical review of the payments on a routine basis. Department staff have access to Colorado Works payment information on the COIN system; however, the Department does not review COIN to identify possible problems. For example, department staff could review diversion payments by focusing on payments issued by individual county caseworkers, on large diversion payments, and on recurring payments to the same recipients. This type of analytical review is important in order to provide ongoing and timely feedback to the counties. In this way, the Department can supplement the feedback to counties that is provided under the on-site monitoring plan, which is designed to cover all 64 counties over a four-year period. Information from the analytical review could also aid the Department in identifying high risk counties and scheduling the on-site visits.

In addition to reviewing payments through case file reviews and analyzing COIN data, the Department should provide additional guidance to the counties to further assist them in becoming aware of and adhering to program requirements. While federal and state regulations have given wide discretion in determining what payments are appropriate under Diversion Programs, there are specific requirements that must be met for eligibility and for allowable types of expenditures. The problems we identified reflect payments that appear questionable under state and/or federal requirements and, thus, in a number of instances could be disallowed by the federal government.

Finally, the Department should ensure efforts are made to recover all overpayments made with public funds, regardless of whether or not it classifies payments as "public assistance." The Department should require that counties develop policies to recover identified overpayments under diversion in a timely manner. We believe that this should be a consistent requirement across all county plans with diversion components.

Federal regulations require that the Department ensure federal requirements are met for funds passed through to the counties. Similarly, while state law grants the counties broad authority to administer their Colorado Works programs, statutes place the ultimate

authority for ensuring compliance with state laws and regulations with the Department. Sec. 26-2-716(4) (a,b), C.R.S., states:

> A county may not use county block grant moneys except as specifically authorized pursuant to the provisions of this part 7 [Colorado Works] and rules promulgated by the state board or state department. . . If the state department has reason to believe that a county has misused county block grant moneys and has given the county an opportunity to cure the misuse and the county has failed to cure, the state department may reduce the county's block grant for the succeeding state fiscal year by an amount equal to the amount of moneys misused by the county. Any county found out of compliance with its performance contract or any provision of the works program may be assessed a financial sanction . . . .

Therefore, the Department should ensure that state and federal requirements are met for state and county diversion under Colorado Works.

(CFDA No. 93.558; Temporary Assistance for Needy Families; Activities Allowed or Unallowed, Allowable Costs/Cost Principles.)

Recommendation No. 77:

The Department of Human Services should establish adequate controls to ensure that Colorado Works expenditures for diversion are in compliance with state and federal requirements and meet the intent of the program by:

a. Reviewing diversion case files as part of its periodic and ongoing TANF/Colorado Works monitoring process at county departments of social services. This process should include timely follow up with the counties on issues identified and resolution of problems.

b. Using COIN data on diversion payments to perform periodic risk analyses on counties' Diversion Programs. Results of the analyses should be used to assist with decisions on scheduling county Diversion Program monitoring visits and to perform other follow up as appropriate.

c. Developing written policies defining expenditures that are consistent with requirements and with the legislative intent of the diversion program and communicating these policies to all county departments of social services.

d. Requiring that all counties identify policies in their annual county plans submitted to the Department to identify and recover diversion overpayments in a timely manner. The Department should review the implementation of counties' recovery policies during Diversion Program monitoring visits.

Department of Human Services Response:

Agree.

a. The ongoing county program reviews include diversion-specific questions that will focus on the accuracy of payments, state and/or federal law compliance, and county compliance with its own policies. The Department will then issue a detailed report with recommendations to the county and forward copies to the Department's Audit Division. Based on the reviews, appropriate counties will receive more intensive training. Implementation date: October 2002 and ongoing.

b. The Department will initiate periodic risk analyses on counties' Diversion Programs. These results will be utilized as part of the overall county monitoring process. Implementation date: October 2002.

c. Written policies defining expenditures that are consistent with requirements and legislative intent is a good control; however, these policies are already defined in state and federal statute and regulations, and county social service departments have had and continue to have access to this information on a regular basis. The Department will continue to provide counties with guidance on these policies and help in the development of policies at the local level. Implementation is ongoing.

d. Federal TANF law does not require counties to recover overpayments. Colorado statute gives counties the programmatic flexibility and funds to make these decisions at the local level. However, the Department will require that all counties identify policies in their annual county plans with regards to recovery of diversion overpayments. The Department, through its ongoing county program reviews, will verify proper implementation of the county recovery policies contained in the annual county plan. Implementation date: October 2002 and ongoing.

County Plans

Another weakness in the Department's oversight of the diversion program is its lack of review of county plans. Counties are required by their performance contracts with the Department of Human Services to submit plans annually to the Department that outline their Colorado Works program policies and procedures. As discussed, state law provides counties discretion in creating and implementing their Colorado Works programs while still requiring them to adhere to federal and state TANF rules. We identified problems with two of the nine county plans we reviewed for Calendar Year 2001. In one case, the plan outlines the county's creation and implementation of a separate program component that is not consistent with state or federal TANF regulations. The problems we identified with this particular component of that county's plan are described in the next section of this report.

In the second plan in which we identified problems, the plan noted that the county would make diversion payments to recipients for unreimbursed medical expenses. However, TANF regulations do not allow medical services other than prepregnancy services to be provided with TANF grant funds. In addition, this county did not provide an income limit for county diversion in its county plan, although state regulations require counties to establish income maximums for county diversion eligibility.

In its federally required biannual State Plan for the TANF program, the Department states that it is responsible for assuring that all counties are complying with the terms of their county plans. This is consistent with the Department's responsibilities as the primary recipient of federal TANF funds. However, the Department has no process in place for reviewing annual county Colorado Works plans. Some of the inappropriate payments identified in our audit could likely have been prevented if the Department had reviewed the counties' plans and provided feedback regarding program aspects that did not appear to be in line with state and federal regulations.
(CFDA No. 93.558; Temporary Assistance for Needy Families; Activities Allowed or Unallowed, Allowable Costs/Cost Principles.)

Recommendation No. 78:

The Department of Human Services should institute a formal review process for county Colorado Works annual plans by:

a. Assigning staff to review annual county plans.

b. Establishing a method for providing feedback to counties regarding appropriateness of their plans within a specified time frame (e.g., 30 days) of submittal and ensuring that required changes are made timely.

c. Determining counties' compliance with their county plans through ongoing case file reviews.

Department of Human Services Response:

Agree. The Department agrees that improvements regarding the appropriateness of counties plans with regard to state and federal compliance issues can be achieved. Determining compliance with plans and policies through ongoing case file reviews is already a part of the established county program review process. As part of the ongoing county program reviews of all 64 counties within the next four years, the Department will conduct a thorough review of counties' plans and policies and provide specific feedback to counties regarding issues of non-compliance with regulations. Additionally, the Office of Self Sufficiency will work internally with the Department's Divisions of Field Audits and Field Administration and externally with county departments themselves to establish a review tool to more effectively and timely review counties' plans and policies. It is anticipated that after development of this review tool, feedback would be given to counties within 90 days of plan submittal. Implementation date for parts (a) and (b) within 90 days of receipt of new county plans starting January 1, 2003. Implementation date for part (c) October 2002 and ongoing.

Requirements for Allowable Programs

Several of the counties we reviewed have instituted Colorado Works Diversion Programs for families leaving basic cash assistance because the recipient had obtained employment, and therefore, the family's resources exceeded eligibility requirements for these ongoing cash payments. We found that one county's program for these families, referred to as its "transitional" program, does not appear to meet certain federal or state requirements. For example, under this transitional program, the county appears in some instances to be providing recurring cash payments instead of using county diversion to address families' short-term needs. Out of the 13 county diversion cases from this county in our sample, in 12 instances recipients received recurring diversion benefit payments during Calendar Years 2001 and 2002 to meet multiple, general, ongoing needs rather than a demonstrable,

specific, short-term need. In addition, the payments and/or families did not appear to meet other county diversion requirements. The problems we found are identified below (some cases had more than one problem).

- **Nine of the families each received between 9 and 34 cash payments during Calendar Years 2000 and 2001.** One of the nine families received 27 payments over the two-year period, including four rent payments and two car insurance payments. The insurance payments each covered a full year of premiums. Under federal regulations, "transitional" services are to be paid only for stabilization of housing or transportation, and the payment must be for a nonrecurrent, short-term benefit addressing a discrete crisis rather than ongoing needs. Total payments to families ranged from $3,121 to $7,000.

- **Seven of the families received cash payments in six or more consecutive months. In one case, the family received payments for 11 consecutive months.** Federal regulations that apply to diversion state that cash payments to recipients are limited to four consecutive months for a specific need. Our file review indicated that the same ongoing needs were being used by the county as the basis for payments beyond the four-month limit.

- **Six of the families did not appear to meet income guidelines for the county's Diversion Program.** State regulations require that families served in county diversion must not be eligible for basic cash assistance or state diversion. For these six families, both the case files and Department of Labor and Employment records indicate the families had low income levels that would *require* that they be served through either basic cash assistance or state diversion; county diversion is intended to serve families at higher income levels. These six families received a total of 119 county diversion payments during the two-year period totaling $24,203.

- **Three recipients that received a total of 32 county diversion payments totaling $9,000 did not work at all or worked only a few months during the two-year period we reviewed.** While regulations do not require that diversion recipients be employed, we question whether payments to chronically unemployed individuals meets the goals of Colorado Works to promote job preparation and ensure participation in work activities as soon as possible. Our review of file documentation indicated these recipients were receiving payments on the basis of long-term ongoing needs throughout the period, rather than for short-term crises. We also noted that by placing these recipients in diversion, the county was not required to include these recipients when calculating its work participation rate.

Additionally, we noted that because the county was providing ongoing cash payments to these recipients through diversion, these payments were not being counted against the recipients' 60-month TANF life-time limits for ongoing cash assistance. We believe this is a misuse of county diversion. Federal and state regulations require that in order for cash payments to qualify as "nonassistance" or diversion, the payments must be solely for short-term or transitional needs. If the payments do not meet these requirements, then the payments are considered cash assistance and must be counted against a recipient's lifetime limit for cash assistance payments.

The county believes the ongoing cash payments under its transitional program are permitted by TANF regulations under the category of "other assistance." However, we are concerned that under both federal and state TANF regulations, "other assistance" is intended to provide support services (e.g., child care) to employed families that are receiving basic cash assistance. "Other assistance" is not intended to take the form of cash payments, and it is not intended for unemployed persons or "post-TANF" individuals after leaving basic cash assistance. Therefore, it appears that the county is using its transitional program to make payments that are not allowable under federal regulations either as "other assistance" or as "nonassistance" (i.e., diversion).

The county stated that its transitional program was not part of diversion and, therefore, was not subject to federal or state TANF/Colorado Works regulations. However, the county is using TANF funds to make payments under its transitional program, and the county is reporting the payments on COIN as TANF diversion payments. This transitional program is therefore part of the TANF/Colorado Works program.

The Department should take immediate action to ensure federal and state requirements are clear to counties and that counties are in compliance with these requirements. This should include completing a detailed review of this county's plan, as discussed in the previous recommendation, and requiring the county to make necessary changes to the plan. Additionally, the Department should perform an extension of the case file review undertaken in our audit with appropriate follow up at all counties that have in place "transitional" Diversion Programs to identify all instances of possible noncompliance. These steps are critical to ensuring the program is operating according to regulations and that any instances of possible fraud or irregularities are identified and addressed. As stated earlier in this report, the Department should also ensure that all counties with diversion as part of their Colorado Works program have policies in place to recover diversion overpayments.

In addition to the risks of noncompliance and misuse presented by this situation, we are concerned that this county's transitional Diversion Program is, in effect, being used in some instances to provide ongoing cash assistance with no time limits. This is contrary to one

of the basic intents of Colorado Works and TANF: to end dependence on government benefits.

(CFDA No. 93.558; Temporary Assistance for Needy Families; Activities Allowed or Unallowed, Allowable Costs/Cost Principles Matching, Level of Effort, Earmarking.)

Recommendation No. 79:

The Department of Human Services should take immediate steps to address the problems identified in the audit regarding county "transitional" programs under TANF/Colorado Works diversion. This should include:

a. Conducting detailed case file reviews of recipients and payments under county transitional programs and addressing and resolving instances of noncompliance with federal and state regulations.

b. Ensuring that counties are adequately informed about the requirements that must be met in order for payments or services to appropriately be classified as "other assistance" under TANF.

Department of Human Services Response:

Agree.

a. As part of the ongoing county program reviews of all 64 counties within the next four years, the Department will include some diversion-specific questions that will focus on whether the payments made were accurately, within state and/or federal law, and within the county's own policies. A detailed report of any noncompliance issues and recommendations for resolution will be issued to the county with a copy sent to the Department's Audit Division. Further, counties identified with having a significant number of noncompliance issues will be targeted for more intensive training. Implementation date: October 2002 and ongoing.

b. The Department will continue to provide guidance to counties—through training, agency letters, technical assistance, etc.—on the policy requirements, both federal and state, that must be met and the areas where there is flexibility to develop county-specific policies. Implementation is ongoing.

IEVS Verification

The TANF program has considerably more flexibility than Aid to Families with Dependent Children (AFDC), the program TANF replaced. However, under TANF the federal government continued one of AFDC's basic requirements: that recipients' income information and identity be verified through the federal Income, Eligibility, and Verification System (IEVS) at the time of application. IEVS provides states with income information on TANF recipients from the Social Security Administration, Internal Revenue Service, and the Colorado Department of Labor and Employment. Through IEVS, recipients' social security numbers are matched with these agency's records to identify instances in which TANF recipients have potentially understated their earned and unearned income and resources. This requirement must be met for all TANF applicants, regardless of whether they are applying for basic cash assistance or another type of assistance such as diversion.

In our review, we found that although the Department reports that it verifies information on TANF applicants for basic cash assistance through IEVS, the Department does not use IEVS to verify the accuracy of reported income for either state or county diversion recipients.

Staff explain that they have not run diversion recipients' social security numbers through IEVS since the inception of the Colorado Works program because diversion clients receive a one-time payment and the State might not be able to locate the client to recover an overpayment by the time the IEVS match identified a discrepancy. However, federal regulations require that information on all TANF applicants, including those applying for diversion, be screened through IEVS. In addition, we noted that many clients receive more than one diversion payment throughout the year. Therefore, IEVS could identify discrepancies with applicant-provided information that could be investigated and resolved prior to a recipient's returning for additional assistance.

Under federal regulations, states can be penalized for failure to conduct IEVS matches by up to 2 percent of the total TANF grant award. For Colorado, a 2 percent penalty since the inception of the TANF program in Federal Fiscal Years 1998 through 2001 would result in a penalty of $11.6 million.

(CFDA No. 93.558; Temporary Assistance for Needy Families; Eligibility.)

Recommendation No. 80:

The Department of Human Services should verify identity and income information submitted by applicants for Colorado Works diversion by:

a. Processing all diversion applicants through the federal Income and Eligibility Verification System (IEVS) on a timely basis.

b. Submitting all identified identity and income discrepancies to the counties for investigation and follow-up to ensure discrepancies are resolved promptly.

c. Requiring counties to address and resolve discrepancies identified through IEVS in a timely manner. In instances where discrepancies exist, if counties use alternative information to determine eligibility, the Department should ensure that counties obtain verification of this information.

Department of Human Services Response:

Agree.

a. Agree. The Department shall create an automated process by which all applications for federal TANF benefits are processed through the IEVS system. Implementation date October 2002.

b. The Department will continue to follow the Settlement Agreement of Darts, et al. v. Berson Civil Action No. 91-S-1003 that required the Department to implement minimum verification requirements for applicants and verify earned income, social security numbers and pregnancy. Other verification may be required if the information provided by the applicant is questionable. The lawsuit settlement allows the State Department to verify only those items directly relating to eligibility for public assistance. Implementation is ongoing.

c. The Department will issue guidance to counties regarding timely identification and resolution of discrepancies identified through IEVS. The guidance issued will also include verification of any alternative information utilized to determine eligibility. Implementation date: September 2002.

Case File Documentation and Verification

We also found that counties need to improve case file documentation. In some case files, documentation was not sufficient to determine if payments made to recipients were appropriate, and in other instances, required documents were lacking. Both state and federal regulations require states and counties to maintain adequate case records related to services provided. Case records should assist caseworkers reach valid decisions, ensure assistance is based on factual information, and provide for continuity when a caseworker is absent or when a case is transferred. The Department requires counties to, at a minimum, obtain an application, an Individual Responsibility Contract (IRC), and documentation of income earned in the last 30 days. Federal and state regulations both require the maintenance of records regarding applications, determinations of eligibility, and the provision of financial assistance.

We identified problems with the documentation for clients' diversion payments at each of the nine counties we reviewed. These problems were identified in a total of 16 cases (some files had more than one error and may appear in more than one category below).

- **Seven case files could not located by county staff.** These recipients received about $18,400 in diversion payments in Calendar Year 2001.

- **Five case files contained no supporting documentation for payments totaling about $4,200.** Thus, the counties were unable to substantiate the payments' appropriateness and adherence to program regulations.

- **Five case files involving payments of over $12,200 did not contain a state-required Individual Responsibility Contract (IRC).** This contract specifies the recipient's need for assistance and the type of assistance being provided, the county's expectations and terms for the recipient, and the reason the participant does not need a basic cash assistance grant.

Program Overpayments

In addition to the need to maintain adequate documentation, we found that state regulations were not being followed that require verification of applicant-provided information not confirmed through IEVS. Specifically, state rules require counties to verify additional information not verified through IEVS such as identity, residency, family composition, income not reported in IEVS, and any other factors required that affect eligibility, such as specific need for a type of assistance under diversion. Department rules require counties to obtain and verify a social security number for each individual listed on the Colorado Works application, income earned by each family member within the past 30 days, and

pregnancy if not observable. Verification is defined as confirming the correctness of information by obtaining written evidence or other information that proves such fact or statement to be true.

In total, we found that counties did not properly verify applicant-provided information in 54 (23 percent) of the 239 cases in our sample. In some instances, this resulted in the counties issuing improper payments. The nonverified information included income, employment, identity, and specific need for a type of assistance. We also found that four of the nine counties reviewed do not require applicants to provide social security cards, identification cards, or any other proof of identity. They only require an applicant to provide a social security number for each of the family members. Lack of requirements for adequate documentation and verification increase the risk of fraud and irregularities occurring within the Diversion Program.

We identified three specific overpayments that resulted from the lack of verification:

- **One county discovered it had overpaid a recipient by $9,630. When staff attempted to recover the overpayment, they found the recipient had provided false information and was not eligible for any payment.** Staff discovered that the recipient's children were not living in the household, the employment information was false, and the home address was not a residence but a business. If this information had been validated prior to payment, this situation could have been averted. While the county had made attempts to recover the overpayment, as of the end of our audit the county had not been successful in recovering any of the overpayment from the recipient.

- **Another county inappropriately paid two recipients $9,240 in county diversion, although the recipients' incomes exceeded the county limit for the program.** Proper verification of the recipient-provided income information might have prevented the overpayments.

In one of these latter instances, the recipient was a TANF caseworker in one of the county departments. This individual received diversion payments totaling $5,000, despite the fact that the person's income exceeded the county's maximum level for county diversion. The county had excluded routine overtime pay in the calculation of the individual's income, although information on both regular and overtime pay were documented in the file. Overtime pay must be included in the calculation of income.

Issuing benefits to county workers is an area of potential conflicts of interest, and counties should have policies in place to ensure such applications are handled appropriately. While the county had a policy requiring management review of such decisions, the county did not

perform adequate verification of supporting documentation to determine the payment was appropriate.

Documentation and Verification Policies

Regulations require verification of recipient-provided information and define verification as obtaining written evidence proving the information is correct. This indicates that the information should be maintained in recipient case files. Colorado Works rules also state that a county cannot delay payments to applicants while waiting for information from IEVS "if other appropriate verifications are obtained to determine eligibility." Thus, counties must verify essential applicant-provided information through IEVS or alternate sources prior to authorizing payments.

Counties note that regulations do not provide detail about how much documentation must be maintained in case files. Through its policies and procedures the Department should ensure that applicant-provided information is verified and that case files contain appropriate documentation to ensure payments are made to eligible individuals, payment amounts are appropriate, and payments are adequately supported. As part of the annual county plans, the Department should require that counties identify policies for granting TANF benefits to county employees. Policies should ensure payments are made only to eligible individuals and address conflict-of-interest issues.

(CFDA No. 93.558; Temporary Assistance for Needy Families; Activities Allowed or Unallowed, Eligibility.)

Recommendation No. 81:

The Department of Human Services should ensure information in Colorado Works diversion case files is adequate by:

a. Establishing and communicating policies that outline the type of documentation related to eligibility to be maintained in county case files for diversion recipients.

b. Ensuring that counties implement existing state regulations requiring verification of specific applicant-provided information, as well as other information affecting eligibility for diversion.

Department of Human Services Response:

Agree.

a. The Department will continue to provide guidance to county departments of social services on the types of documentation necessary to be included in case files for diversion recipients through its various training/information-sharing opportunities, such as its annual professional development conference, its quarterly administrator meetings and through its ongoing county program review process. Implementation is ongoing.

b. County departments are required to meet all requirements of Darts, et al. v. Berson, Civil Action No. 91-S1003 and at a minimum verify earned income, social security numbers and pregnancy if not observable for all applicants. County departments may, under current Colorado Works rules (3.604.1 C), require verification of any information that is questionable or inconsistent as documented in the applicant's case file. Through the county monitoring activities, training and agency letters the Department will monitor case files to assure that case files include appropriate documentation and verification consistent with state Colorado Works rules. Implementation is ongoing.

Recommendation No. 82:

The Department of Human Services should require that counties have policies in their county plans for granting any TANF benefits or services to county employees. Policies should ensure that eligibility determination is performed in compliance with state and federal requirements and with the county plan, and that potential conflict-of-interest issues are addressed.

Department of Human Services Response:

Agree. The Department will require counties to include in their county plan a policy for granting TANF benefits or services to county employees. In a county-administered system, counties make decisions on the appropriateness of and the eligibility for any payments under the TANF program. The Department will encourage counties to establish fair and objective policies for the provision of diversion payments to staff in their employ, including the review of such requests by an impartial party prior to such payment being made. Implementation date January 2003: and ongoing.

Low-Income Energy Assistance Program Overview

The Low-Income Energy Assistance Program (LEAP), within the Department of Human Services, is a federal program that was created in 1980 to provide low-income households with assistance to help meet the cost of their winter home heating needs. LEAP is a state-supervised, county-administered program. That is, the Department is responsible for the general oversight of LEAP while county social services offices are responsible for administering the Program by determining eligibility and calculating benefit amounts. The Program contains two main components:

- **Basic LEAP Benefit** - This is a cash benefit that is paid to either a utility company or fuel supplier on behalf of eligible households, or directly to eligible households when heating costs are included in rent. Individuals can apply for cash benefits from November through April each year. Counties have 50 calendar days to process standard, non-emergency applications. Emergency applications, where a shutoff notice has been received or a shutoff has already occurred, must be processed within 10 working days upon receipt.

- **Crisis Intervention Program (CIP)** - This is assistance for households experiencing a non-fuel-related heating emergency. Heating emergencies typically include situations where a furnace or a broken window needs to be repaired or replaced. Eligible households qualify for up to $1,200 worth of repairs each year. Individuals can apply for CIP assistance year-round. Counties have four working days to process applications for CIP services.

During Fiscal Year 2002 the Office of the State Auditor conducted a performance audit of the Low-Income Energy Assistance Program. The audit comments below were contained in the *Low-Income Energy Assistance Program, Department of Human Services Performance Audit,* Report No. 1419, dated June 2002.

Documentation in Case Files

Department rules require that counties obtain sufficient documentation to support eligibility determinations and benefit calculations. For example, applicants must provide documentation to verify their reported income for the month prior to application and vulnerability to rising heating costs (i.e., copy of their most recent heating bill, or when heat is included in rent, a copy of their most recent rent receipt).

During our review of about 400 files from Program Years 2001 and 2002, we found that many did not contain sufficient documentation to support eligibility determinations, benefit calculations, and adherence to timeliness standards. Specifically, we found:

- 14 out of 61 files (23 percent) requiring a rent receipt did not contain one.
- 38 out of 346 files (11 percent) requiring a heating bill did not contain one.
- 44 out of 406 files (11 percent) did not contain income verification.

We also looked at approximately 300 of the files to determine if the documentation contained in the files was date stamped. Counties are required to date stamp all documentation so that reviewers can determine if applications are processed within appropriate time frames. We found that about 40 of the files (13 percent) contained documentation that was not date stamped.

In addition, we found that most applicants did not provide social security numbers or birth dates for additional household members. The Department requests that the individual applying for benefits include his or her social security number and date of birth on the application. Although the application also requests social security numbers and birth dates for additional household members, this information is not required before an application is processed. Requiring this information would help ensure that applicants accurately report the total number of household members. This is important because eligibility determinations are affected by income and household size. That is, as household size increases, so do the maximum income requirements. In addition, the larger the household, the higher the benefit payments. Inappropriately increasing household size may improve an applicant's ability to be eligible for LEAP and increase benefit awards.

The Department also finds numerous errors during its own monitoring process. In the nine recent county monitoring reports we reviewed, the Department reported errors in 69 of the 160 cases reviewed. These errors ranged from minor issues such as incorrect coding to more serious issues such as incorrect income calculations and eligibility determination mistakes. Without proper documentation it is difficult to determine if eligibility and benefits were calculated correctly. As a result, some applicants may receive benefits that they are not eligible to receive.

(CFDA No. 93.568; Low-Income Home Energy Assistance; Eligibility.)

Recommendation No. 83:

The Department of Human Services should ensure that counties sufficiently document information used to determine eligibility, calculate benefit amounts, and determine adherence to timeliness standards for the Low-Income Energy Assistance Program by:

a. Requiring applicants to provide a social security number and date of birth for every household member.

b. Continuing to emphasize at trainings the supporting documentation that must be included in every file and the importance of date-stamping the documentation.

Department of Human Services Response:

a. Disagree. Although the provision of social security numbers is not required by federal statute or regulation, the Department currently requests, but does not require, social security numbers and birth dates for identification purposes. The vast majority of applicants either provide them on their LEAP application or counties access them through other benefit programs for identity purposes. The Social Security Number is not used for verification, federal matching, or other purposes. The requirement would cause delays in processing applications—forms would have to be returned as incomplete. Because LEAP is a time-sensitive program, these delays would be detrimental to applicants. Requiring date of birth would serve no value.

Auditor's Addendum: ***Obtaining social security numbers for all household members serves at least two important purposes. First, social security numbers provide a unique identifier for LEAP recipients that would assist the Department in tracking recipients across other benefit programs. In addition, requiring this information would help ensure that applicants accurately report the total number of household members, and thus receive the appropriate benefit amount.***

b. Agree. LEAP trainers currently stress the need to include supporting documentation in case files and on the Report of Contact screen in the LEAP automated system. They will continue to do so. LEAP conducts formal, intensive training each fall, prior to the beginning of the new program year, for all county workers. Implementation date: September 16, 2002.

Timely Application Processing

We reviewed the timeliness of the county LEAP offices' processing of standard, emergency, and CIP applications and found that timeliness was an issue, especially for the emergency and CIP applications. There are many reasons why it is important that counties process all applications within the specified time requirements. In CIP cases, for example, there may be health or safety concerns because an applicant has a cracked furnace that is leaking carbon monoxide. In emergency cases applicants may have their heat shutoff which can also lead to health and safety issues. We found that:

- **28 of 47 (60 percent) Crisis Intervention Program cases reviewed exceeded the Department's four-working-day processing requirement by 1 to 65 days.** On average, it took counties about eight working days to process these cases. Department rules currently require CIP cases to be *processed* within four working days of the county's receiving an application. In addition, the rules require that counties provide some form of assistance within 48 hours of application to homes experiencing a heating crisis or within 18 hours if the situation is life-threatening. There are no requirements, however, for when CIP *services* must be provided. From our review of CIP case files, we found that it was often difficult to determine when services were actually provided due to a lack of documentation. Insufficient documentation also made it difficult to determine if a county took intermediate steps, such as supplying space heaters or blankets, to assist applicants until a permanent repair could be made. The ultimate goal of CIP is to provide services to households in need. Therefore, it is important that these services be provided as soon as possible. In addition to having a requirement that counties *process* CIP applications within four working days, it would be beneficial to also have a requirement for counties to ensure *services* are actually provided within a certain time frame.

- **34 of 135 (25 percent) emergency cases reviewed exceeded the Department's 10-working-day processing requirement by 1 to 70 days.** A majority of the cases that exceeded the 10-working-day requirement were from the 2001 LEAP season when many counties experienced difficulties due to a significant increase in applications. In emergency cases, Department rules require counties to process applications within 10 working days and contact the utility vendor as soon as they receive an application to prevent service from being discontinued. During our file review we were able to evaluate the number of days it took to process the emergency applications. The files, however, did not usually contain sufficient documentation to show when the utility vendor was contacted.

- **38 of 274 (14 percent) standard cases reviewed exceeded the Department's 50-day processing requirement by 1 to 66 days.** A majority of the cases that exceeded the 50-day requirement were from the 2001 LEAP season when many counties experienced difficulties due to a significant increase in applications. For the other years, most cases were processed within the 50 days. Consequently, we question whether 50 days is too long and whether counties should be required to process standard LEAP applications within a shorter time frame. We surveyed other states' programs to determine their time requirements for processing standard LEAP applications in order to compare them with Colorado's requirements. We found that a majority of the states surveyed have a 30-day time requirement for processing standard applications. In fact, Colorado's 50-day requirement is the longest of the states surveyed that have established time requirements.

(CFDA No. 93.568; Low-Income Home Energy Assistance; Other.)

Recommendation No. 84:

The Department of Human Services should improve the timeliness of the Low-Income Energy Assistance Program application process by:

a. Implementing a time requirement for counties related to the amount of time counties have to provide Crisis Intervention Program services.

b. Continuing to emphasize to county personnel at trainings the importance of documenting all actions taken on a case.

c. Evaluating the 50-day time requirement for processing standard applications and taking steps to reduce the number of days.

Department of Human Services Response:

a. Partially agree. Department rule 3.756.20 requires LEAP to provide "some form of assistance" within 48 hours, and within 18 hours for life-threatening situations, which the program is meeting. Such assistance is for stopgap measures to alleviate the immediate crisis. It is impractical to set a time limit for the provision of a permanent remedy, e.g., a new furnace, as the program

cannot control the time it takes contractors to obtain parts and equipment. Implementation date: October 1, 2002.

Auditor's Addendum: ***As noted in the discussion, we found that it was often difficult to determine when services were actually provided due to a lack of documentation. This includes both stopgap measures and permanent remedies. Although the Department and the counties may not be able to control the exact date permanent services are provided, it is still important that both make a concerted effort to ensure services are provided as quickly as possible.***

b. Agree. LEAP trainers currently stress the need to collect or cite supporting documentation. Such documentation may be located in the LEAP case file or cited on the Report of Contact (ROC) screen in the LEAP Management Information System as being located in another program case file, such as Food Stamps, TANF, or Adult Categories. Implementation date October 1, 2002.

c. Partially agree. The auditors' comparison to other states' time limits may be inappropriate, as programs are often dissimilar from one state to another. Nevertheless, the Department will evaluate the 50-day ceiling to determine if shortening it will jeopardize the program's ability meet any new limit while continuing to place a priority on addressing emergency cases. LEAP must first process applicants facing service discontinuance or heating system emergencies, while ensuring non-emergency applicants are processed and receive benefits in a timely manner. Implementation date October 1, 2002.

Tracking Administrative and Outreach Expenditures

Each year, the Department allocates a portion of LEAP funding for administrative expenses. These funds are intended to cover the actual cost of operating LEAP. Administrative expenses include items such as salaries, facility costs, and postage for disseminating eligibility notices. Federal statutes limit the amount of funds a state may use for planning and administering LEAP to 10 percent of the State's total federal allocation. In Fiscal Year 2001 the Department could have used up to about $4 million for administrative costs at both the state and county levels. The Department reports that in

Fiscal Year 2001 the State and the counties spent a total of $2.6 million, or 6 percent of the federal allocation, to administer LEAP.

The Department also sets aside funding for outreach activities. Outreach funds are allocated from the basic LEAP benefit pool. There are no federal limitations on the amount a state can spend on LEAP outreach, but limiting these expenses is important because funding comes from the dollars allocated for benefits. In Fiscal Year 2001 the State and the counties spent almost $624,000 on outreach. Outreach activities include sending out applications to prior LEAP recipients and individuals receiving public assistance, distributing posters and handouts, and placing advertisements in newspapers. The purpose of these activities is to inform potentially eligible individuals about LEAP and the benefits that are available.

County administrative and outreach allocations are determined on the basis of caseload. That is, the previous year's caseload is used to determine what proportion of the funds set aside the next year for local-level administrative and outreach costs the next year a county will receive. For example, if a county's Fiscal Year 2000 caseload represented 5 percent of the total state caseload, that county would have received 5 percent of the total funding allocated for county administrative costs and 5 percent of the total funding allocated for county outreach costs in Fiscal Year 2001.

During our audit we reviewed the Department's method for tracking administrative and outreach expenditures and found there are inadequate controls in place to ensure the Department is complying with the federal 10 percent limitation on administrative expenditures. For example, although the Department reported that its administrative expenditures for Fiscal Year 2001 represented only 6 percent of its federal allocation, the problems with timekeeping and accounting practices discussed below made it impossible for us to determine if this figure was accurate. Further, although expenditures may be reviewed by the Department's internal audit unit and through other state-level monitoring processes, none of these monitoring approaches are frequent or thorough enough to provide the necessary assurance that counties are appropriately charging administrative and outreach expenses. County LEAP offices are required to document and report all administrative and outreach expenditures in the Department's County Financial Management System. This system tracks county expenditures for all human services programs and allows counties to specifically code LEAP expenditures as either an administrative or outreach expense. We found several problems with how counties currently track LEAP expenditures. Specifically:

- **Some counties do not use any of their LEAP administrative or outreach allocations.** In Federal Fiscal Year 2001 we found that seven counties did not

charge anything to the LEAP administrative cost code, even though they had LEAP caseloads ranging from 24 to 204 cases. Although county staff obviously spent time processing these cases, none of this time was charged to LEAP, resulting in an understatement of administrative costs. In addition, in Federal Fiscal Year 2001 there were 16 counties that did not charge any expenditures to the LEAP outreach code. Counties are allocated outreach funds and are required to conduct outreach in their communities. These counties either did not conduct any outreach during this time period or did not appropriately charge LEAP for their expenditures.

- **Some counties do not use one of the Department's approved time reporting methods to document the time staff spend managing and processing their LEAP caseloads.** During our review we found that three of the ten counties we visited did not use one of the Department's approved time reporting methods to account for the staff time spent on LEAP. Department policy requires counties to document the amount of time staff spend on a particular program by using direct time reporting, 100 percent time reporting, or random moment sampling (RMS). Direct time reporting is used when staff spend all of their time on LEAP. Generally, direct time reporting is used by larger counties that have LEAP-only staff. We did not find any problems in this area. In many small- and medium-sized counties, however, staff may work on several programs at once because LEAP caseloads are not sufficient to warrant a full-time employee. When staff split their time between multiple programs, they must use 100 percent time reporting or RMS to determine how much time should be charged to a particular program. With 100 percent time reporting, staff must track the time they spent on a program, using 15-minute increments. This information is then used to allocate personal services costs to the appropriate program. With RMS, staff are selected at random and asked on what program they are working. Software is then used to project the average time spent on each program for each staff member and to allocate expenses. Four of the smaller counties we visited have staff who work on multiple programs at one time. Three of these counties, however, do not use 100 percent time reporting or RMS. These three counties also have not been charging LEAP for any of the time that staff spend on this program. We were unable to determine how the counties accounted for their time or if the time was inappropriately charged to other programs. If staff time is being spent on LEAP and the costs associated with this time are not properly allocated to LEAP, administrative costs will be understated.

- **The amount that counties spent of their LEAP administrative and outreach allocations varied significantly.** In Federal Fiscal Year 2001, 46 counties

underspent their $1.9 million administrative allocations by almost $610,000 (33 percent), and 27 counties underspent their $269,000 outreach allocations by almost $132,000 (49 percent). Conversely, 15 counties over-spent their $227,000 administrative allocations by a total of about $88,000 (39 percent), and 11 counties overspent their $60,000 outreach allocations by a total of about $57,000 (95 percent).

During our review we found that it is difficult to determine the reasons for the expenditure variances. According to the Department, most over- and under-expenditures are due to coding errors by the counties. That is, counties code expenses as administrative when they should be coded as outreach or vice versa, even though the Department provides training to county staff on the appropriate coding of LEAP expenditures. In addition, although the Department requests an explanation when it identifies overexpenditures, it does not require that counties provide documentation to explain why the error occurred. We also found that although the Department has provided counties with a list of approved outreach expenditures, it has not provided them with a list of approved administrative expenditures. These lists would assist counties in determining how expenses should be coded and could reduce the number of coding errors that occur. Further, if the overexpenditures are not the result of coding errors, then the Department's policy is to recover the excess by deducting that amount from the county's appropriation the following year. The Department, however, has enforced this policy only once in the past three years.

Although we recognize that some of the underexpenditures may be due to county efficiency, others may be due to problems with the Department's allocation methodology. As mentioned previously, the Department allocates administrative and outreach funds on the basis of caseload. Because such a large number of counties are not spending the amount allocated, caseload may not be the most appropriate basis for determining county allocations.

(CFDA No. 93.568; Low-Income Home Energy Assistance; Allowable Costs/Cost Principles, Reporting.)

Recommendation No. 85:

The Department of Human Services should improve the accuracy of county administrative and outreach expenditure reporting for the Low-Income Energy Assistance Program by:

a. Ensuring counties use one of the approved methods for reporting the time staff spend managing and processing LEAP cases.

b. Developing and disseminating specific guidelines on the appropriate uses of administrative funds.

c. Continuing to emphasize to county program and fiscal staff the importance of appropriately coding LEAP administrative and outreach expenditures.

d. Requiring counties to fully document reasons for overexpending administrative and outreach allocations and/or recovering county administrative and outreach overexpenditures each year.

e. Reassessing its methodology for allocating funds.

Department of Human Services Response:

a. Agree. The Department issued an Agency Letter in 2002 instructing county human services departments to use one of the approved methods for personnel time tracking. Implementation date: November 1, 2002.

b. Agree. The Department will develop these guidelines and train county staff on their application at LEAP training. The Department will also issue these guidelines to each county human services department through the agency letter process. Implementation date: November 1, 2002.

c. Agree. The Department will continue providing this instruction as part of its ongoing training of county business office staff. Implementation date: November 1, 2002.

d. Agree. The Department currently requires counties to document the reasons for administrative and outreach over-expenditures, and will continue to do so. Department staff also notifies counties why over-expenditures are being recovered. Implementation date: November 1, 2002.

e. Agree. The Department recently convened a state/county task force, which recommended that the outreach allocation methodology be modified. As part of this, the Department will implement an Outreach Incentive Program beginning this winter. Implementation date: November 1, 2002.

Program Oversight

As mentioned previously, the Department is responsible for monitoring LEAP to ensure that the program is administered in accordance with state and federal requirements. This includes monitoring county LEAP offices to ensure cases are processed properly and monitoring utility vendors to ensure LEAP benefits are applied to the appropriate accounts. During our review we identified several issues related to the Department's current monitoring process. Specifically, we found:

- **Many counties have not been reviewed for a significant period of time.** Specifically, 8 counties have not been monitored since 1989 and 34 counties have not been monitored since 1996. In addition, we found that the Department's current process does not allow for timely follow-up with counties when errors are found. In nine recent county monitoring reports that we reviewed, the Department reported errors in 69 of 160 cases. Errors included incorrect income calculations, inappropriate eligibility determinations, untimely application processing, and inadequate supporting documentation. According to the Department, counties are required to prepare a corrective action plan that addresses the errors. During our review, however, we found that many counties did not submit a corrective action plan until months after the monitoring visit. Even when counties did submit a corrective action plan, the Department did not follow up with the counties in a timely manner to ensure the appropriate corrective actions were taken.

- **Payments to utility vendors are not monitored to ensure they are applied to the appropriate customer accounts.** The agreements between the State and utility vendors contain a provision that allows the Department to monitor client benefit payments. The Department has not monitored these payments in the past but has instead relied on clients to notify the Department if the correct benefit amount is not credited to their account. Monitoring would help ensure that individuals receive credit for the full LEAP benefit amount for which they are eligible.

Department rules require state LEAP staff to develop a monitoring plan that should include provisions for programmatic and local reviews and methods for ensuring corrective actions are taken in a timely manner. We found that the Department has not developed a formal monitoring plan or schedule for reviewing county LEAP offices. According to the Department, because it has a limited number of staff and limited time to devote to monitoring, it has focused its efforts on larger counties because these counties process a majority of the State's LEAP cases and because these counties often have high staff turnover. Staff have also stated that they visit counties that have asked for technical

assistance or seem to be experiencing difficulties. This approach results in many small- and medium-sized counties not receiving the proper oversight by the Department.

In addition, at each county visited, the Department interviews county staff and reviews 20 case files to determine if eligibility and benefit amounts were calculated correctly and to see if the files contain sufficient supporting documentation. We believe that the Department may need to set guidelines to expand the number of files it reviews at counties when a significant number of errors are identified. For example, the Department may decide that if 20 percent or more of the files reviewed contain errors, a larger sample should be selected so that the root cause of the errors can be determined. We found that for eight of the nine county monitoring reports we reviewed, the Department found errors in 20 percent or more of the cases contained in its sample. Further, the Department found errors in 50 percent or more of the cases reviewed at five of the nine counties. These results indicate that more oversight is needed to ensure eligibility and benefits are calculated correctly.

In addition to the monitoring conducted by state LEAP staff, the Field Audits Section within the Department conducts county financial compliance audits for county-administered social services programs. Although these audits are not necessarily program specific, Field Audits staff have stated that they will monitor areas of concern identified by program staff. Currently, however, LEAP staff do not regularly inform the Field Audits Section of the counties they have monitored or of problem areas identified during their review. Without this information, Field Audits staff will not know to focus on LEAP while performing their financial compliance reviews at specific counties where problems have been found. State LEAP staff could maximize their monitoring coverage by maintaining better communication with the Field Audits Section.

(CFDA No. 93.568; Low-Income Home Energy Assistance; Subrecipient Monitoring.)

Recommendation No. 86:

The Department of Human Services should improve its oversight of the Low-Income Energy Assistance Program by:

a. Developing a plan for monitoring county LEAP offices which establishes a review cycle that ensures every county gets audited on a regular basis and that tailors file reviews to consider factors such as caseload size, previous problems noted, and any other relevant factors.

b. Enforcing the requirement that counties prepare a corrective action plan in a timely manner to address any problems discovered by Department staff during their

review and following up on these plans in a timely manner to ensure problems have been remedied.

c. Periodically monitoring a sample of benefit payments made directly to utility vendors to ensure funds are credited to the appropriate LEAP client accounts.

d. Maintaining better communication with the Field Audits Section regarding the counties that have been monitored and any areas of concern identified.

Department of Human Services Response:

a. Agree. Although there are no federal statutory or regulatory requirements for monitoring, the Department currently maintains a schedule, which places a priority on monitoring counties with the largest caseloads. LEAP staff also place a priority on monitoring counties with discernable issues and those that request state assistance. LEAP will continue in this manner, prepare a five-year monitoring plan, and do everything it can to review all counties periodically. Staff will continue to tailor reviews according to the above noted factors. Implementation date: August 1, 2002.

b. Agree. The Department currently enforces this requirement, will continue to do so, and will follow up to ensure compliance. Implementation date: August 1, 2002.

c. Disagree. LEAP presently makes payments electronically to utility companies, which then electronically credit them to customer accounts. There is little room for misapplication of these payments. In addition, clients receive notices advising them of their benefit amounts, when the payment will be made, and to whom. The Department, through its Field Audits Division, investigates, as requested by clients or counties, the rare complaints against utility vendors. This has worked very effectively.

Auditor's Addendum: ***Periodically verifying that LEAP payments are credited to the appropriate account is a basic control that should be in place to ensure public dollars are being used appropriately.***

d. Agree. LEAP has maintained excellent communication and a strong working relationship with Field Audits over the years and will continue to share information with them including results of monitoring reviews and areas of concern. Implementation date: August 1, 2002.

Crisis Intervention Program Funds

As mentioned previously, the purpose of the Crisis Intervention Program (CIP) is to provide assistance to low-income individuals who are experiencing a home heating- related crisis. According to Department rules, a home heating-related crisis includes the following:

- Heating system failure.
- Window breakage.
- Emergency snow removal.
- Emergency clothing, blankets, shelter, and/or alternative fuel provision.
- Energy costs to operate a life support system.
- Any other crises related to home heating costs, other than the payment of utility/fuel bills.

LEAP households are eligible to receive up to $1,200 in CIP services each year. When a county LEAP office receives a CIP application, the county technician will process the application and then contact either a private vendor or the Energy Saving Partners (ESP) weatherization agency in the area about the emergency. The vendor or weatherization agency will then go out to the home and determine what repairs are needed and the estimated cost of the repairs. Because of the emergency nature of the situation, the vendor or weatherization agency will usually call the county LEAP technician to receive verbal approval for the repair. Once the services are provided, the private vendor or weatherization agency bills the county LEAP office for materials and labor. In Fiscal Year 2001 about 1,900 LEAP households received CIP services.

During the audit we interviewed county staff and reviewed case files to determine what steps are taken to ensure appropriate CIP services are provided. We found that staff at only two of the ten counties we visited follow up with CIP clients to ensure that the private vendor or weatherization agency provided the appropriate services. Instead, staff report that they rely on CIP clients to call and complain if their heating problem is not fixed. Currently neither the Department nor the counties are required to conduct any type of follow-up on CIP cases to ensure repairs were completed and funds were used appropriately. A follow-up phone call by county staff to the CIP recipient would provide some assurance that the work was actually completed. In addition, we observed during our file review that most vendors and weatherization agencies provide a very limited description of the services provided and materials used for the repair on the invoices submitted to the county LEAP offices. A more detailed invoice would provide county staff a written record of the work completed and the materials used and make the vendor or weatherization agency more accountable for the repairs.

In addition to the actions described above, requiring clients to sign a form indicating that work has been completed for CIP cases is another step the Department could take to

ensure that CIP funds are used appropriately. We found that the Governor's ESP Program already has a similar requirement in place for homes receiving weatherization services. The Department could require that clients sign the detailed invoice described above to indicate that the appropriate services were provided. In addition, contingent on funding availability, the Department could contract with independent private vendors around the State to inspect a sample of homes where CIP repairs were made to verify that the work described in the invoice was actually completed. Although none of these steps alone will ensure that CIP funds are used appropriately, all of them used in conjunction will provide more assurance than is currently obtained.

(CFDA No. 93.568; Low-Income Home Energy Assistance; Subrecipient Monitoring.)

Recommendation No. 87:

The Department of Human Services should improve its oversight of the Crisis Intervention Program by:

a. Requesting that county LEAP offices randomly follow up with individuals receiving CIP services to ensure that the appropriate services were provided.

b. Requiring private vendors and weatherization agencies to submit detailed invoices to county LEAP offices that clearly describe the CIP services provided and materials used and that contain a client signature indicating the appropriate services were provided.

c. Periodically contracting with independent private vendors to inspect a sample of the homes where CIP repairs were made to verify that the work described in the invoice was actually completed.

Department of Human Services Response:

a. Disagree. LEAP will require contractors to obtain recipient signatures affirming that the CIP work was completed and to submit detailed invoices (see "b" below). This should be adequate to ensure the services were provided. Also, we rely on customer complaints to alert us if the work is not satisfactory. While clients rarely complain about the services provided, LEAP staff address their issues when they do. Of approximately 1,900 CIP recipients in 2001-02, LEAP received very few complaints.

b. Agree. Rules have been drafted and will be presented to the Colorado Board of Human Services in August 2002, which, if passed, will require counties to

obtain detailed invoices and client signatures for all CIP jobs. Implementation date: October 1, 2002.

c. Disagree. As noted above previously, the Department receives very few complaints about the quality of CIP work. New requirements that recipients sign statements affirming the work was satisfactorily completed, and that contractors submit detailed invoices, should be sufficient verification for the vast majority of CIP jobs. The Department will refer any subsequent client complaints to Field Audits if counties or program staff cannot resolve them. Hiring private vendors for inspections is not necessary.

Auditor's Addendum: ***Approximately $1 million is spent each year to provide CIP services. It is the Department's responsibility to establish the controls necessary to ensure these funds are spent appropriately. Randomly following up with CIP recipients to verify that the appropriate services were provided would not be a very time consuming process, yet it would provide additional assurance that public funds are being used for their intended purpose. In addition, many of the CIP repairs are complicated and technical in nature. Having an expert inspect some CIP repairs would provide an additional control over the expenditure of these funds.***

Division of Child Welfare Services

The Division of Child Welfare Services directs the development of the child welfare care system by providing resource and policy development, technical assistance, monitoring and oversight. All direct services are administered by county departments of social services. Four programmatic areas define the target populations served in child welfare: Youth in Conflict, Child Protection, Children in Need of Specialized Services, and Resource Development.

Subsidized Adoption Program Overview

In Colorado children can be adopted through private organizations or through county departments of human services/social services. Children available for adoption through county departments typically enter the State's child welfare system as a result of abuse and neglect and cannot be returned to their parents. Finding adoptive homes for these children, many of whom have serious physical, mental, and emotional disabilities, can be difficult, in part, because of the financial burdens imposed by their special needs. Colorado's Subsidized Adoption Program (the Program) plays a key role in placing these special

needs children into permanent adoptive homes. The Program helps reduce financial barriers to adoption by providing assistance such as regular monthly adoption subsidies paid to the families and Medicaid coverage for the child. Additionally, the State and counties may pay for certain types of services not covered by Medicaid or the monthly subsidies, such as therapies and respite care. In Fiscal Year 2000 adoption subsidies were provided to families in 97 percent of the cases where adoptions were finalized. The Program benefits not only the special needs children who are placed in permanent homes, but also the State by reducing the high costs of foster care for these children.

Colorado's Subsidized Adoption Program is overseen by the Department of Human Services' Division of Child Welfare Services (the Division) and administered at the local level by county departments of human/social services. Colorado's Subsidized Adoption Program consists of both a state/county program and a federal Title IV-E adoption assistance program. For monthly adoption subsidies under the federal Title IV-E adoption assistance program, the State contributes 30 percent of the funding, the counties 20 percent, and the federal government a 50 percent match. For subsidies that are not eligible for Title IV-E reimbursement, the State contributes 80 percent and the counties 20 percent of the funding.

During Fiscal Year 2002 the Office of the State Auditor conducted a performance audit of the Subsidized Adoption Program. The audit comments below were contained in the *Subsidized Adoption Program, Division of Child Welfare Services, Performance Audit,* Report No. 1386, dated March 2002.

Subsidy Payments Discontinuance

According to federal statutes and Department rules and regulations, adoption subsidies must end when a child reaches 18 years of age. The exception to this requirement is if the child's special need includes a physical or mental disability that specifically warrants the continuation of the assistance, in which case the subsidy can continue until age 21. For example, from the subsidy files we reviewed, we found that a child with cerebral palsy or Down's Syndrome would qualify for continuation of subsidy payments past age 18. If a child does not meet the exception criteria, the subsidies are to be discontinued the month following the child's 18th birthday.

We found that 17 of the 20 counties in our sample have a policy to continue adoption subsidies past the child's 18th birthday if the child is still in high school regardless of whether the child has physical or mental disabilities that warrant the continuation. Typically, counties extend payments until a child graduates because the child is still under the care of the parents and some of these children are educationally delayed and do not graduate at or near their 18th birthday. Division managers indicated that despite the current regulations,

they have authorized counties to continue adoption subsidies until children graduate from high school using only state and county funds.

Payments of Unauthorized Subsidies

From our review of subsidy files we found that counties continuing adoption subsidies after children turned age 18 used federal Title IV-E funds to pay the subsidies. In our sample of 79 cases where the adoption subsidies ended in Calendar Years 1999 and 2000, we identified 24 cases (30 percent) where adoption subsidies were paid past the child's 18th birthday for reasons other than the child's having a mental or physical disability. Furthermore, for all of the Title IV-E cases discontinued between 1995 and 2000, we identified 219 cases (22 percent) that remained open past the child's 18th birthday. Accounting for cases that would be eligible for payments past age 18 due to mental or physical disabilities, we estimate that ineligible payments past a child's 18th birthday during this six-year period cost $466,000. About $233,000 of this amount is from federal Title IV-E funds.

According to the federal liaison for Colorado's Subsidized Adoption Program, if the State continues to pay subsidies using IV-E funds after a child's 18th birthday and the child does not have a physical or mental disability, the State is liable to the federal government for these federal funds. Therefore, the Division may be required to reimburse the federal government for the federal portion of the unallowed payments made over the past six years. The Division should determine the amount of unallowed payments that were made to families and work with the federal government to determine the method and amount of repayment. Additionally, the Division should direct counties to comply with current requirements to stop all subsidy payments after the child's 18th birthday unless the child has a physical or mental disability that warrants extension.

(CFDA No. 93.659; Adoption Assistance; Activities Allowed or Unallowed, Allowable Costs/Cost Principles, Eligibility.)

Recommendation No. 88:

The Division of Child Welfare Services should ensure the State is in compliance with federal and state requirements regarding subsidy payments after children reach the age of 18 by:

a. Developing and communicating written policies that are in compliance with federal and state requirements.

b. Monitoring adoption subsidy payments on a regular basis.

c. Working with the federal government to determine the method and amount of repayment for disallowed costs.

Division of Child Welfare Services Response:

Agree. The Department will monitor subsidy payments as part of its annual monitoring plan. Implementation date: September 1, 2002.

As part of the Division's meetings with the federal government, the Department will address written policy and disallowed costs and communicate this information to county departments.

Guidance on Paying Subsidies

On occasion an adopted child may be placed out of the adoptive home for a period of time, either to receive treatment related to behavioral or mental health issues or to address alleged abuse or neglect. We found that counties use a number of approaches for handling adoption subsidies when children are placed out of the adoptive home. This is because the Division has not provided clear direction to counties on managing subsidies when this situation occurs. Typically, counties continue the adoption subsidy during the period of the out-of-home placement. However, some counties suspend the payments if the placement is due to abuse or neglect. When counties continue the subsidy during an out-of-home placement, they may assess a fee to the adoptive family to help cover the out-of-home placement cost. We found the following procedures were in use in the seven counties we visited:

- One county always assesses fees for out-of-home placements when the adoption subsidies are continued.
- Two counties sometimes assess fees for out-of-home placements. In these counties the fee assessment practices varied from case to case.
- One county never assesses fees for out-of-home placements when subsidies are continued.
- One county, at the time of our site visit, did not have a policy for assessing fees for out-of-home placements for subsidy cases. This county is in the process of developing a policy because it recently experienced its first out-of-home placement for a subsidy case.

- Two counties discontinue all subsidy payments when children are placed out of the home. As a result, these counties do not need to assess fees.

Reimbursement for Children Placed Outside of the Adoptive Home

During our audit, we identified 18 cases in our sample of 168 cases (11 percent) where children were placed out of the adoptive home. Nine cases involved the child's being placed out of the home due to behavioral issues and nine cases involved abuse or neglect situations. We found that counties handled subsidies for these cases as follows:

- Payments were continued in 13 cases (72 percent). In seven of these cases, fees were assessed for the out-of-home placements. In the remaining six cases, no fees were assessed.

- Payments were suspended in four cases (22 percent).

- Payments were initially suspended in one case (6 percent) but were later reinstated because of requirements stated in the Department rules and regulations. No fees were assessed in this case.

We estimate counties spent more than $21,000 in monthly adoption subsidies for the seven cases where adoption subsidies were continued and fees for the out-of-home placements were not assessed to the adoptive families. When counties continue adoption subsidies for children in out-of-home placement without charging a fee for the placement, the government is essentially making double-payments for the care of the child during the out-of-home placement period. This is because children who are temporarily removed from their adoptive homes are typically placed in Residential Treatment Centers, Residential Child Care Facilities, or in foster homes, all of which are funded by federal, state, and county sources.

Department rules and regulations authorize counties to assess fees to families whose children are placed out of the home. These fees cannot exceed the monthly adoption subsidy payments to the family. The regulations do not stipulate a procedure for assessing fees. In addition, the Division does not examine financial records when conducting reviews of county subsidized adoption programs. As a result, the Division has not identified the inconsistencies in the ways counties handle subsidies when adoptive children are placed out of the home.

Alignment of State Regulations with Federal Requirements

Federal statutes and policies do not specifically address how adoption subsidies for Title IV-E cases should be handled when a child is temporarily placed outside of the adoptive home. However, they do describe the following circumstances in which a subsidy can be terminated:

- The child attains the age of 18, or 21 in cases where the State determines that the child has a mental or physical handicap which warrants continuation of assistance.

- The State determines that the parents are no longer legally responsible for the support of the child.

- The State determines that the child is no longer receiving any support from the parents.

Further, Title IV-E adoption subsidies can be reduced or stopped if the adoptive parents agree to the change.

The Department has attempted to provide guidance to counties in this area. Specifically, a guidance letter issued by the Department in 1997 states that if a child who is Title IV-E eligible is placed out of the home for any reason, the adoption subsidy must be continued. Similarly, in a written response to a county inquiry in January 2001, the Department stated that subsidies cannot be suspended for Title IV-E cases when children are placed out of the home. However, these directives do not appear to be consistent with the Department rules and regulations, which state:

- The county department shall terminate adoption assistance payments for subsidized adoption when the child is removed from the adoptive home because of abuse or neglect.

- When a child is receiving a state/county only subsidy and is absent from the home for over 30 calendar days, the adoption assistance payments and case services subsidy will be discontinued.

- Children with a Title IV-E adoption assistance subsidy who are out of the home for over 30 calendar days will continue to receive an adoption assistance payment, unless the child is removed from the home because of abuse or neglect.

Division staff told us that they sent the revised rules and regulations cited above to the U.S. Department of Health and Human Service but have not received a response regarding the consistency of the requirements with federal law.

Our review of county procedures found that counties are unclear on how to handle adoption subsidies in out-of-home placement situations. As a result, it is important for the Division to establish and communicate to counties a clear policy on managing adoption subsidies when children are placed out of their adoptive homes. This policy should explain when counties should suspend adoption subsidies for children placed out of their homes and describe the procedures counties should use to assess fees for out-of-home placements. The Division should ensure that this policy is consistent with federal requirements by meeting with federal representatives on this issue and obtaining a written statement regarding the policy. Additionally, Division staff should ensure that counties are complying with this policy by reviewing cases involving out-of-home placements as part of their annual monitoring reviews.

(CFDA No. 93.659; Adoption Assistance; Eligibility.)

Recommendation No. 89:

The Division of Child Welfare Services should improve how counties handle adoption subsidies when children are temporarily placed out of their adoptive homes by:

a. Developing a written policy that clearly describes procedures for subsidy payments when children are placed out of their adoptive homes and that is consistent with both state and federal statutes and policies.

b. Providing training and technical assistance to counties regarding the written policy.

c. Ensuring that counties comply with the policy by reviewing financial records as part of its monitoring reviews.

Division of Child Welfare Services Response:

Agree. The Department will develop a written policy to address the use of subsidy payments and will provide this information during the month Adoption Supervisors meetings and at regional training sessions. The monitoring reviews will be expanded to include reviewing of financial records. Implementation date: August 1, 2003.

Department of Labor and Employment

Introduction

The Department of Labor and Employment is responsible for providing services to employers and job seekers, and enforcing laws concerning labor standards, unemployment insurance, workers' compensation, public safety, and consumer protection. Please refer to page 45 in the Financial Statement Findings section for additional background information.

Cash Management Improvement Act

The Cash Management Improvement Act of 1990 requires the timely transfer of funds between a federal agency and a state, and the exchange of interest where transfers are not made in a timely fashion. The law requires each state to enter into an agreement with the U.S. Secretary of the Treasury, which establishes the procedures the State will use to carry out transfers of funds. According to the U.S. Treasury-State Agreement, State Treasury is responsible for determining the clearance patterns for warrants and electronic funds payments. On the basis of this information, the State Treasurer determines the draw pattern, or how soon federal reimbursements should be requested after the expenditures occur. The draw patterns agencies are required to use for each federal program are included in the Treasury-State Agreement. The Treasury-State Agreement indicates that if the draw patterns and funding techniques listed in the Agreement are followed by each respective agency, no federal or state interest liability will occur. If draw patterns change during the year, the U.S. Treasury must be notified.

Our audit identified three areas of concern with how the Department of Labor and Employment is meeting its responsibilities under the federal cash management requirements:

1. The Unemployment Insurance Benefits (CFDA No. 17.225) drawdowns are not in agreement with the draw pattern established in the U.S. Treasury-State Agreement. The draw pattern in the Agreement is four days. However, the actual draw pattern used by the Department is one day. Therefore, the Department is drawing federal funds sooner based on the terms of the Agreement.

2. The funding techniques used for the Unemployment Insurance Administration and the Unemployment Insurance Benefits (CFDA No. 17.225, Fiscal Year 2002 expenditures = $37,378,649) are not in agreement with the funding techniques stated in the U.S. Treasury-State Agreement. The funding techniques allowed are either "average," which allows the Department to request reimbursement for expenditures on a daily basis, always a certain number of days after the expenditure, or "composite," which allows accumulation of disbursements for an entire week before requesting disbursements. The funding techniques used differ with the Agreement as follows:

    - The Unemployment Insurance Administration is listed as average. The Department uses the composite funding technique.

    - The Unemployment Insurance Benefits funding technique is listed as composite. The Department uses the average funding technique.

3. The funds request and receipts time for Labor-Non-Unemployment Trust Fund (administration expenses) are not in agreement with the request and receipts time stated in the U.S. Treasury-State Agreement. The funds request and receipts times for these programs are stated as "same day" in the Agreement, but Department of Labor and Employment is actually using "next day." In other words, the Department requests federal funds one day later than the Agreement requires.

If the Department does not use the draw patterns and funding techniques prescribed in the Agreement, there is the risk that the State will lose interest on general funds or incur an interest liability when draws are made too early.

(CFDA Nos. 17.225; Unemployment Insurance; Cash Management)

Recommendation No. 90:

The Department of Labor and Employment should work with the State Treasurer to ensure that its draw methods and funding techniques achieve interest neutrality with the federal government.

Department of Labor and Employment Response:

Implemented. The Department of Labor and Employment feels that it has attained interest neutrality with the federal government through its draw methods and funding techniques and that the Department has attempted to communicate this information to the State Treasury on several occasions. The U.S. Treasury-State Agreement does not properly reflect the draw patterns and funding methods used by the Department, even though that information has been communicated to the Treasury. Following are the Department's comments to the three areas of concern:

1. The Cash Management Improvement Act of 1990 allows the State to draw down Unemployment Insurance Benefits when the warrants are issued. The Department has elected not to do that, but to draw down the funds on the same day the funds leave the UI Benefit account. The draw pattern of four days in the US Treasury-State Agreement does not reflect what the Department is doing, nor does it reflect interest neutrality.

2. The Unemployment Insurance Administration funding technique is listed as "average" in the U.S. Treasury-State Agreement when, in fact, it is "composite." The Unemployment Insurance Benefits funding technique is listed as "composite" when it is "average." Both funding techniques were communicated to the State Treasury accurately, but were somehow transposed when the agreement was written.

3. For all other federal administrative dollars, the "composite" method is used and funds are requested on the third day after warrant issue for receipt on the fourth day per the warrant clearance pattern established by the State Treasury. The U.S. Treasury-State Agreement states we are drawing down funds for same-day receipt when, in fact, the funds are received the day after they are requested. Again, this fact has been communicated to the Treasury, but is not stated correctly in the agreement.

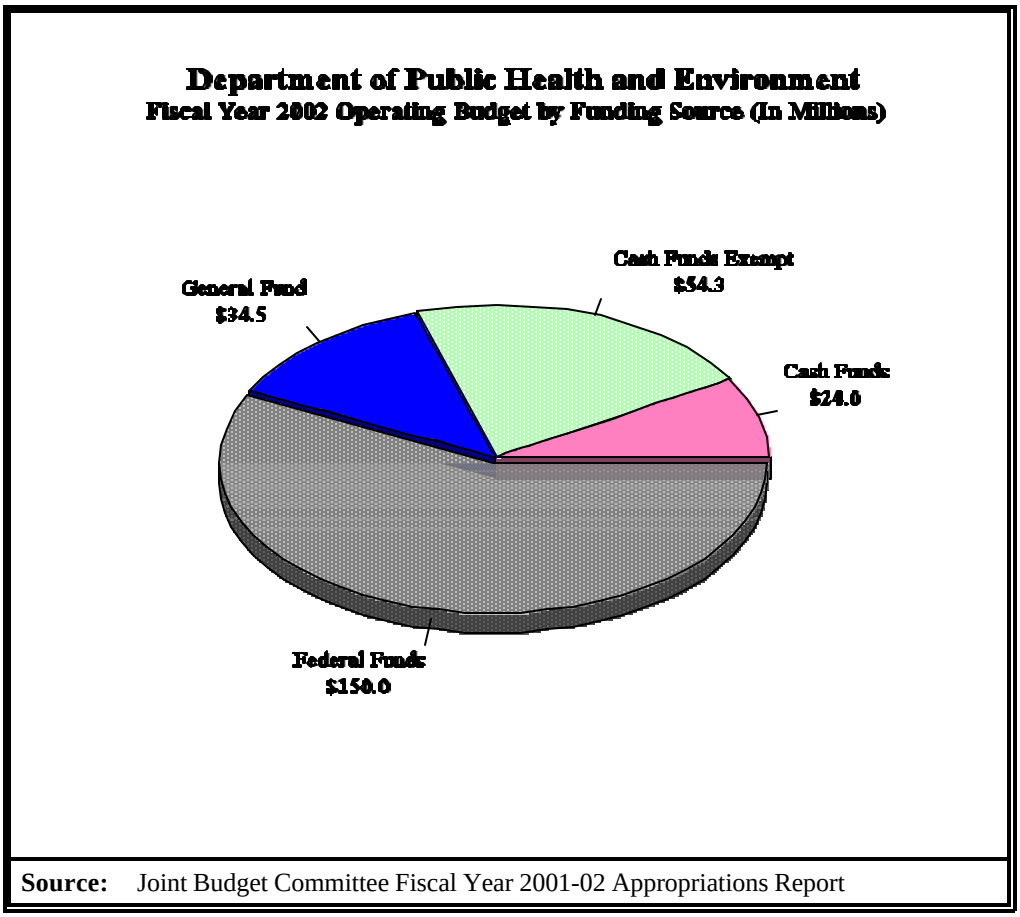
Department of Public Health and Environment

Introduction

The Department of Public Health and Environment is responsible for improving and protecting the health of the people of Colorado, maintaining and protecting the quality of Colorado's environment, and ensuring the availability of health and medical care services to individuals and families. The Department is composed of the following major organizational units:

- Administrative Divisions
  - < Administration and Support
  - < Center for Health and Environmental Information
  - < Laboratory and Radiation Services
  - < Local Health Services
- Environmental Divisions
  - < Air Quality Control
  - < Water Quality Control
  - < Hazardous Materials and Waste Management
  - < Consumer Protection
- Health Services Divisions
  - < Disease Control and Environmental Epidemiology
  - < Family and Community Health Services
  - < Health Facilities
  - < Emergency Medical Services and Prevention
  - < Prevention and Intervention Services for Children and Youth

The Department was appropriated $262.8 million and 1,092 full-time equivalent staff (FTE) for Fiscal Year 2002. The following chart shows the operating budget by funding source during Fiscal Year 2002.



Source: Joint Budget Committee Fiscal Year 2001-02 Appropriations Report

Cash Management Improvement Act

The Cash Management Improvement Act of 1990 requires the timely transfer of funds between a federal agency and a state, and the exchange of interest where transfers are not made in a timely fashion. The law requires each state to enter into an agreement with the U.S. Secretary of the Treasury, which establishes the procedures the State will use to carry out transfers of funds. According to the U.S. Treasury-State Agreement, State Treasury is responsible for determining the clearance patterns for warrants and electronic funds payments. On the basis of this information, the State Treasurer determines the draw pattern, or how soon federal reimbursements should be requested after the expenditures occur. The draw patterns agencies are required to use for each federal program are included in the Treasury-State Agreement. The Treasury-State Agreement indicates that if the draw patterns and funding techniques listed in the Agreement are followed by each respective agency, no federal or state interest liability will occur. If draw patterns change during the year, the U.S. Treasury must be notified.

Our audit identified several areas of concern with how the Department of Public Health and Environment is meeting its responsibilities under the federal cash management requirements. The following programs at the Department are included in the Treasury-State Agreement.

Department of Public Health and Environment
Programs Included in the Treasury-State Agreement

Program	CFDA No.	Fiscal Year 2002 Expenditures
Women Infants and Children Program (WIC)	10.557	$56,517,948
Child Care and Adult Food Program (CCAFP)	10.558	$22,450,806
Superfund-Summitville Program	66.802	$ 9,123,277

Source: Office of the State Auditor analysis of Department of Public Health & Environment records.

During our audit we found that the Department draws down funds for the WIC and CCAFP four days after the expenditures are approved on the State's accounting system. Warrants are issued the next business day after the expenditures are approved. This means that the federal funds are received on the fourth day after the warrants are issued. The Agreement states that the Department should follow a five-day draw pattern. The Department believed that it was following a five-day draw pattern. However, it is unclear from the Agreement whether the payment approval date or the warrant issue date is the first day of the draw pattern. In Recommendation No. 93 of this report, we recommend that the State Treasurer clearly define the terms used in the Agreement in order to ensure that agencies are correctly implementing the required draw patterns.

For the Superfund-Summitville Program, we found that the Department uses a composite rather than an average funding technique as required by the Agreement. An average funding technique allows the Department to request reimbursement for expenditures on a daily basis, a certain number of days after the expenditure is incurred; a composite funding technique allows accumulation of disbursements for an entire week before requesting disbursements. The Department draws twice a week because the Department only receives expenditure reports necessary to do the draws that frequently.

If the Department does not use the draw patterns and funding techniques prescribed in the Agreement, there is the risk that the State will lose interest on general funds or incur an

interest liability when draws are made too early. The Department should clarify its understanding with State Treasury of the terms and methods described in the Agreement to ensure that the State achieves interest neutrality.

(CFDA Nos. 10.557, 10.558, 66.802; Special Supplemental Nutrition Program for Women, Infants, and Children, Child and Adult Care Food Program, Superfund State, Political Subdivision, and Indian Tribe Site - Specific Cooperative Agreements; Cash Management.)

Recommendation No. 91:

The Department of Public Health and Environment should work with the State Treasurer to ensure that the next amendment to the State-Treasury Agreement reflects the cash draw methods and funding techniques that achieve interest neutrality with the federal government.

Department of Public Health & Environment Response:

Agree. Implementation date: July 1, 2003.

Office of the State Treasurer

Introduction

The Office of the State Treasurer is established by the State Constitution. The Treasurer is an elected official who serves a four-year term. Please refer to page 95 in the Financial Statement Findings section for additional background information.

Cash Management Improvement Act

The Cash Management Improvement Act (CMIA) regulates the transfer of funds between federal and state agencies for federal grants. The CMIA regulations require the State to match the time between incurring expenditures for federal programs with state general funds and requesting and receiving federal reimbursement. States are required to enter into a Treasury-State Agreement (Agreement) with the U.S. Treasury. This Agreement specifies the procedures that the State will follow to carry out transfers of funds.

The State has completed the third year of the current Agreement. The Agreement lasts five years (until Fiscal Year 2004) and may be modified by either party. In Fiscal Year 2002 there were 30 programs covered by CMIA at the Departments of Education, Health Care Policy and Financing, Human Services, Labor and Employment, Local Affairs, Public Health and Environment, and Transportation. These programs had federal expenditures of about $1.4 billion in Fiscal Year 2002.

Amending the Treasury-State Agreement

Sections 4 and 5 of the Agreement identify the programs and agencies covered by the Agreement based on the program expenditure threshold of $10 million in federal funds. These sections should be amended each year to add programs and agencies that are expected to exceed the established threshold and to delete programs and agencies that are expected to fall below the established threshold.

The Treasurer's Office did not amend the pertinent sections of the Treasury-State Agreement based on the most current and accurate information available. As a result, certain programs not meeting the required threshold were included and certain programs that do meet the required threshold were not included. In particular, based on the Fiscal

Year 2001 Schedule of Expenditures of Federal Awards, the following programs should not have been included in the Agreement:

Programs Under the $10 Million Threshold		
Program	CFDA No.	Fiscal Year 2001 Expenditures
Employment and Training Assistance	17.246	$773,767
Job Training Partnership Act	17.250	$1,570,727

Source: Office of the State Auditor analysis of Treasurer's Office records.
Note: The programs listed above were below the $10 million threshold but were improperly included in the Fiscal Year 2002 Amendment to the Treasury-State Agreement.

The following program should have been included in the Agreement for the past two years and was not:

Program Over the $10 Million Threshold		
Program	**CFDA No.**	**Fiscal Year 2001 Expenditures**
Adoption Assistance	93.659	$15,051,956

Source: Office of the State Auditor analysis of Treasurer's Office records.
Note: The program listed above was above the $10 million threshold but was improperly excluded from the Fiscal Year 2002 Amendment to the Treasury-State Agreement.

The Treasurer's Office should obtain the most current and accurate information available from both the State Controller's Office and state agencies covered by the Agreement in order to ensure that the correct programs are included in the Agreement. The State Controller's Office can provide a preliminary Schedule of Expenditures of Federal Awards (SEFA) for the current year that could be used in amending the Agreement. For example, the Fiscal Year 2002 Amendment should have been based on the Fiscal Year 2001 SEFA. In addition, agencies should communicate any significant changes in funding levels or program reorganizations resulting in new programs and the elimination of old programs. Without this information, the State risks not including the appropriate programs in the Agreement and, therefore, not meeting cash management requirements for large programs.

(See Appendix A, Office of the State Treasurer, for listing of applicable CDFA Nos.; Cash Management.)

Recommendation No. 92:

The Treasurer's Office should obtain and use the most current and accurate information available on federal program expenditures to annually amend the Treasury-State Agreement.

Treasurer's Office Response:

Partially agree. Since the inception of the Cash Management Improvement Act (CMIA) program in 1993, the Treasury has sought to obtain and use the most current and accurate information available. In Fiscal Year 2002, three grants representing 0.4 percent of the dollars covered by CMIA were erroneously presented in the U.S. Treasury-State Agreement. In no case did these erroneous presentations have an adverse affect on the CMIA program or upon the State of Colorado.

Two of the grants (17.246 and 17.250) were erroneously presented in table 6.3 of the Agreement, but were accurately excluded from Exhibit II . Exhibit II is the primary document used by the various state departments to implement the CMIA program. Consequently, no adverse interest payments to the federal government were caused by this error.

One grant (93.659) was erroneously excluded from Exhibit II. However, this exclusion was due to the information received from the state Department that manages the grant. Further, the Department certified that Exhibit II was accurate. Nevertheless this particular error does have the potential to incur interest costs to the State. Accordingly, the Treasury will develop new communication materials by June 1, 2003, to ensure state departments better understand the information they need to provide to the Treasury.

Compliance With Funding Techniques and Draw Patterns

Section 6 of the Agreement describes and identifies the funding techniques to be used for each program. Exhibit II of the Agreement identifies the draw pattern that should be followed for each program. During our audit at the Department of Public Health and Environment and the Department of Labor and Employment, we found that both

departments were using funding techniques and draw patterns that were different from those prescribed in the Agreement. This was in part because the departments interpreted the terms and methods used in the Agreement differently. We also found that the Department of Human Services was not complying with its established draw pattern.

Failure to follow the correct draw patterns and funding techniques negatively impacts the State either through loss of interest on state general funds when draws are made too late or potential interest liability when draws are made too early. Draw patterns and funding techniques have been established by State Treasury based on studies of payment clearance and cash receipt patterns. Unless the State Treasury determines that changes have occurred in these patterns since the studies were performed, draw patterns and funding techniques should not be modified.

(See Appendix A, Office of the State Treasurer, for listing of applicable CDFA Nos.; Cash Management.)

Recommendation No. 93:

The Treasurer's Office should define the terms and methods used to establish funding techniques and draw patterns and provide the definitions to each department subject to the Agreement.

Treasurer's Office Response:

Partially agree. The Department currently and since the inception of the CMIA program in 1993 has communicated definitions of the CMIA funding techniques and draw patterns to each involved department. These communications include a definition of the point where the elapsed time for federal reimbursement begins. However, one of the seven departments involved in the CMIA program did not correctly implement the funding techniques and draw patterns. This error could have increased interest costs for the State. Accordingly, the Treasury will develop new communication materials by June 1, 2003, to ensure state departments better understand the instructions they receive from the Treasury.